IN THE CIRCUIT COURT FOR
SUMTER COUNTY, ALABAMA

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JIMMY C. ACTON,

Plaintiff,

vs.

No. CV-96-98

R. J. REYNOLDS TOBACCO COMPANY; et al.,

Defendants.

DEPOSITION OF

CAROLINE CHILES, M. D.

WINSTON-SALEM, NORTH CAROLINA

MARCH 17, 1999

ATKINSON-BAKER, INC.
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IN THE CIRCUIT COURT FOR
SUMTER COUNTY, ALABAMA

JIMMY C. ACTON, Plaintiff,	)	
vs.	)	No. CV-96-98
R. J. REYNOLDS TOBACCO COMPANY; et al., Defendants.	)	

Deposition of CAROLINE CHILES, M. D., taken on behalf of Plaintiff, at Womble Carlyle Sandridge & Rice, 200 West Second Street, Suite 1600, Winston-Salem, North Carolina, commencing at 1:00 p.m., Wednesday, March 17, 1999, before Beth A. Broom.

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A P P E A R A N C E S

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I N D E X

WITNESS: CAROLINE CHILES, M. D.

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EXHIBITS

NUMBER	PLAINTIFF'S DESCRIPTION	PAGE
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3-A	PA X-ray 7/22/82	44
3-B	Lateral X-ray 7/22/82	44
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4-B	Lateral X-ray 6/12/85	46
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NUMBER	DEFENDANT'S DESCRIPTION	PAGE
1	Bone Scan 4/19/95	78
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3	Bone Scan 5/13/96	82
4	Bone Scan 9/30/97	84

(All X-rays retained by Mr. Engram, Counsel for Reynolds)

QUESTIONS WITNESS WAS INSTRUCTED NOT TO ANSWER:
(NONE)

INFORMATION TO BE SUPPLIED:

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(Plaintiff's Exhibits 1 & 2 were marked for identification.)

CAROLINE CHILES, M. D.

having first been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. ESDALE:

Q. Would you state your name, please.

A. Caroline Chiles.

Q. And how are you employed?

A. I'm a radiologist at Wake Forest University School of Medicine.

Q. Are you employed by the hospital?

A. I'm employed by the medical school, the hospital then contracts with the medical school for radiology services.

Q. I noticed and I had some directions earlier when this case was set at the hospital and it said it had, is it the Bowman Gray School of Medicine, or is that different?

A. Yes. It's changed its name to the Wake Forest University School of Medicine, the Bowman Gray Campus.

Q. When did that name change occur?

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A. About a year ago.

Q. And it's called the Bowman Gray campus?

A. Yes.

Q. Do you know who Bowman Gray was or is?

A. Yes.

Q. Who is he or was he?

A. He was the president of R. J. Reynolds, I believe, in the '30s.

Q. I'll show you what's been mark as Plaintiff's Exhibit 1. It's a deposition notice. Have you ever seen that before?

A. No.

Q. Let me just ask you then, did you bring any materials with you today?

A. I brought x-rays and CT scans.

Q. Anything else?

A. No.

Q. Have you ever been given anything else in this case other than x-rays and CT scans?

A. Yes.

Q. And what were you given?

A. I was given a large packet of medical records.

Q. Have you reviewed those?

A. I have skimmed some of them but not all.

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Q. Where are those?

A. In my office.

Q. Did you make any notes at any time during this case?

A. No.

Q. Let me show you what's been marked as Plaintiff's Exhibit 2. Have you ever seen that before?

A. Yes.

Q. Attached to or a part of Plaintiff's Exhibit 2 is your CV. Is it current as far as you know?

A. I have a more up-to-date one which I can get for you. This is February of '98. I have one that's from this year.

Q. Do you know just off the top of your head, generally, what is different about the new one as opposed to this one here?

A. I've given some talks, presentations. There's been some publications added but no substantial change.

Q. Did any of those deal specifically with lung cancer or carcinoids, if you recall?

A. There was one paper on a specific type of lung cancer called bronchioalveolar cell carcinoma,

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but that's the only one I recall that's specifically related to lung cancer.

Q. Are any of them, in your opinion, related to your testimony as it relates to this case?

A. No.

Q. Have you ever testified before either by trial or deposition?

A. Once.

Q. When was that?

A. About two weeks ago.

Q. What did that involve?

A. That was a deposition.

Q. What kind of case?

A. It was a malpractice case.

Q. Where did you give your deposition?

A. In the radiology area at Wake Forest.

Q. Who were you working for?

A. An attorney out of Salisbury, and I'm blanking on his name.

Q. Can you tell me a little bit about what the case was about?

A. The case was about a traumatic intubation.

Q. Did you testify on behalf of the plaintiff or defendant?

A. The plaintiff.

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Q. Do you know where that case is filed?

A. No.

Q. Do you know if it's filed in Carolina, North Carolina?

A. North Carolina, yes.

Q. Have you ever been hired for consultation purposes by anyone?

A. Yes.

Q. On how many occasions, if you know?

A. Approximately 10. Ten different cases.

Q. Right. Can you run through those, generally? Are they all med mal? That's the kind of information I'm looking for. If they're all med mal cases, or some of them smoking and health or a mixture.

A. Most of the cases that I have been sent are medical malpractice cases to look at an image, see if a lesion should have been detected when it was not. That's the typical case.

Q. Primarily lung cancer cases?

A. Primarily lung cancer.

Q. Failure to diagnose?

A. Yes.

Q. Okay. Have you consulted in any smoking and health cases?

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A. Yes.

Q. All right. On how many of those, if you know?

A. Eight.

Q. Who did you consult with on those cases?

A. With the attorneys here at Womble Carlyle.

Q. All eight of those cases?

A. Yes.

Q. Do you know how much time you spent in just total in all eight of those cases?

A. Twenty hours, 30 hours, something like that.

Q. Total as opposed to each case?

A. Right.

Q. What are your fees?

A. $300 an hour.

Q. Is that for everything?

A. Yes.

Q. Travel?

A. I don't travel.

Q. What about for trial?

A. I haven't done that.

Q. Are you going to charge $300 an hour for trial if you have to travel to Alabama?

A. I haven't thought about that.

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Q. Have you ever worked for any firm other than Womble Carlyle regarding a smoking and health case?

A. No.

Q. Is it your understanding in each of those cases that Womble Carlyle represented R. J. Reynolds, or did they involve other tobacco companies, if you know?

A. I think they all involved R. J. Reynolds, but I could be mistaken.

Q. As far as the radiology department -- well, let me figure out how I want to go about this. You told me earlier that the school used to be named Bowman Gray, to your knowledge are there any grants or is there any funding that is provided either by Bowman Gray or R. J. Reynolds at Wake Forest?

A. I don't know.

Q. Then I assume -- well, let me ask you, do you know whether the radiology department at Wake Forest School of Medicine receives any funding or grants from R. J. Reynolds, or Bowman Gray, or a fund that he might have set up?

A. Not that I'm aware of.

Q. Have you ever received any funding or grant money from R. J. Reynolds or any funds associated

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with them to your knowledge?

A. No.

Q. I had one question about a -- I think it's a journal article that you wrote. It's number 51 on your CV. I'm sorry, it's number 52.

(Document handed to witness for review.)

Do you recall that article?

A. No. I would remember it if I could see the cover page of it, but off the top of my head I don't remember it.

Q. Does the title of it have any meaning to you?

A. This particular journal has a segment called "A Chest Film Clinic" and I'm one of the editors of that section. And the goal of that section is to present unknown cases to the readers. And so in the title we specifically avoid giving the diagnosis. So this title is a descriptive title.

I remember this -- I remember the case now. It's a descriptive title that tells the reader this is what the case is about, and then the reader has to read the clinical presentation, look at the images, and make their own decision about what the diagnosis is. And so it's sort of -- it's an unknown case presentation. I believe this particular case

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was an example of eosinophilic granulomatosis.

Q. I'm sorry?

A. It was a case of eosinophilic granulomatosis.

Q. My question, I guess, would be also what is the significance of whether or not the, I guess, patient in that case was a smoker or nonsmoker?

A. Any time the patient has a history of smoking there's increased vigilance for smoking-related disorders.

Q. What do you mean by "increased vigilance"?

A. The radiologist needs to look at the film more carefully for any possible smoking-related disorder.

Q. And what are smoking-related disorders?

A. Things that we might see on an x-ray would include respiratory bronchiolitis, emphysema or malignancy.

Q. Is there any way to tell via an x-ray or radiograph whether anything on there is malignant or benign?

A. Yes. There are characteristics that suggest that something is much more likely to be benign than malignant.

Q. Can you give me some of those?

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A. The presence was calcification in a lesion; if it's centrally located or if the lesion is solidly calcified, that's much more likely to be benign. Lesions that are larger in size or have much more irregular margins are more likely to be malignant.

Q. You say irregular margins?

A. Uh-huh.

Q. And are larger in size?

A. Yes.

Q. When you say "larger," what size are you drawing a distinction there?

A. There is no definite threshold for saying that something is benign or malignant, but certainly when you encounter lesions that are greater than three centimeters, there's a greater probability that it would be malignant.

Q. In your other consultations what were you asked to do in those cases? Not every -- specifically every one of them, if you can just give me generally.

MR. STUHAN: I'm going to object to the question in it's qualified to refer to general observations on the ground that the question calls for information protected by the attorney mental impression work product doctrine. I'm instructing

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the witness not to answer that question.

BY MR. ESDALE:

Q. When were you retained in this case?

A. About a year ago.

Q. Just so we're clear, is it my understanding that you have not made any notes or generated any paperwork yourself as a result of your work in this case?

A. That's right.

Q. Do you know how much time you spent on this case thus far?

A. About 10 hours.

Q. How do you keep up with that?

A. I really don't keep up with it very much. I usually send a statement for my time the following day and the attorneys here have kept up with that.

Q. Who were you first contacted by regarding this case?

A. Trisha Scales.

Q. And how were you contacted?

A. By telephone.

Q. These other cases you've consulted in regarding smoking and health, did any of those predate your being contacted in this case?

A. Yes.

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Q. How many of them, if you know? Or let me reask it this way, how many times have you consulted on new cases with Womble Carlyle since you were retained or since you were contacted in this case?

A. I would have to guess. Perhaps two or three.

Q. So I assume then out of the eight then five or six would have been consultations prior to your becoming involved in this case?

A. Yes.

Q. What did Trisha Scales tell you or what did y'all discuss when you were first contacted?

A. I don't remember the specifics of the conversation.

Q. How long did it last, if you know?

A. Probably not very long. None of my conversations at work last very long. I can't remember.

Q. Were you given any information at that time?

A. No. Usually if she contacted me about a case she just tells me she has some x-rays she wants me to look at.

Q. Do you recall when the next time you spoke with anyone regarding this case was?

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A. No.

Q. I assume at some point in time you did speak with someone else or someone again regarding this case?

A. Yes.

Q. When was that, if you know?

A. After she contacted me by telephone we probably set up a meeting and would have been sometime within the next week or two.

Q. What did you do at that next meeting?

A. She showed me some x-rays.

Q. Do you know which x-rays?

A. They were x-rays in 1995 and 1996, I believe.

Q. Were any of those CT scans?

A. Yes.

Q. Were any of them bone scans?

A. No.

Q. Have you looked at any bone scans in this case at all?

A. Yes.

Q. How long did this second meeting with Ms. Scales -- was the second meeting with Ms. Scales?

A. Mr. Engram may have been there. I don't remember exactly who attended.

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Q. How long did that meeting last?

A. I would estimate an hour.

Q. And where did it take place?

A. In the meeting room outside my office.

Q. And do you know how many x-rays you looked at total, including bone scans, CT scans?

A. In the first meeting?

Q. Yes. Well, yes.

A. All I recall is that I did not have the complete set of films. The only CT's I had were post-therapy. And I had some x-rays prior to therapy. So I had a very incomplete set of films, but I don't remember the exact number.

Q. What information were you given other than the x-rays?

A. I don't recall.

Q. Do you know if you were given any medical records at that time?

A. Not at that time.

Q. Do you know if you were verbally given any -- or let me ask you this, what were you asked to do?

A. I was asked to look at the images and help figure out what was going on, which was really tough to do at that time since I did not have a good

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chronological sequence of films.

Q. Okay. So you look at the images and then figure out what was going on? What do you mean by that exactly?

A. To evaluate the abnormalities and formulate a differential diagnosis.

Q. What was your understanding of your request to formulate a differential diagnosis?

A. That's the way I would approach any film that I would encounter on a daily basis. I would first decide if there is an abnormality present; once I see the abnormality I would characterize the abnormality, and then I would consider the most likely causes of that abnormality. So that's what I mean by a differential diagnosis. It's basically a list of the most likely etiologies.

Q. And is it my understanding -- well, did you have any or offer any opinions regarding any of those things at that first meeting?

A. At that time I really couldn't since I did not have baseline films. I did not have the CT that correlated with the -- with the current films. So I did not have enough information at the first meeting.

Q. So I assume you requested to look at the additional films before offering any opinions?

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A. Yes.

Q. When was the next time you had any meeting with anyone in this case, or conversations?

A. I believe it was a couple months later.

Q. Where did that meeting take place?

A. Again, the conference room outside my office.

Q. Who all was present?

A. Trisha Scales would have been there, Mr. Engram may have been there, there may have been someone else from the office. I don't remember the exact attendees.

Q. Were you given any additional information in between the first meeting and this second meeting?

A. Not that I recall.

Q. At the second meeting were you provided additional films?

A. Yes.

Q. How long did the second meeting last?

A. Approximately an hour.

Q. At that time were you given any information or any materials other than additional films?

A. Not at that time.

Q. The first meeting were you left films or did they just bring the films, let you look at them

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and then take them back with them?

A. They took them back with them.

Q. The second meeting, what all films do you recall reviewing, if any?

A. At the second meeting I believe they provided the CT that was obtained prior to any radiation therapy.

Q. Is there anything else at that second meeting that you recall looking at as far as that you wanted to look at from the first meeting?

A. That's all I recall at that point.

Q. Was that the primary film that you didn't have from the first meeting?

A. Yes.

Q. Did you also review other films in addition to the CT that was obtained prior to the radiation therapy at the second meeting?

A. At that time I re-reviewed the films we had had earlier so that I could review them in sequence.

Q. Those would have been the films from '95 and '96?

A. Yes.

Q. Do you recall if the CT you reviewed was a 1995 CT?

A. Yes.

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Q. And was it a '95 CT?

A. Yes.

Q. What, if anything, were you asked to do at that second meeting?

A. Again, to determine if there was an abnormality on the CT and to characterize the abnormality.

Q. Did you offer any opinions at that second meeting?

A. Yes.

Q. And what were those?

A. At that time I could see a mass on the CT which was not visible on the CT's that were obtained following radiation therapy.

Q. What size of mass?

A. Six-by-five centimeters.

Q. Centimeters?

A. Yes.

Q. Would that be considered a large mass?

A. It is a mass. I've seen larger but it is a large mass.

Q. Okay. All right. What other opinions did you offer?

A. The mass was in the right, lower lobe, and I also reviewed the chest x-rays that were obtained

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prior to the CT to determine what abnormality was present and how long it had been there.

Q. What chest x-rays did you review?

A. At that time I had chest x-rays from 1994 and 1995. I may have had some chest x-rays from '96 but I'm not sure.

Q. And what did the x-rays that were taken prior to the CT reveal?

A. The major abnormality that you can see on films prior to the CT is volume loss within the right, lower lobe. And there is also an opacity on the lateral radiographs that initially is somewhat nodular in configuration and then is surrounded by the atelectasis in the right, lower lobe.

Q. Surrounded by what, I'm sorry?

A. Atelectasis or volume loss.

Q. Okay. When you say "opacity," what does that mean?

A. Opacity is a radiographic term that says that there is some substance between the x-ray beam and the film. And that substance blocks the x-ray beam from reaching the film, thereby rendering the film more opaque. And so we would characterize that as opacity. It's the white part of an x-ray.

Q. Does that tell you anything as a

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radiologist?

A. What it would tell me is if I see an opacity that's not part of normal anatomy, then that would tell me that there is an abnormality there.

Q. Does it tell you what type?

A. No.

Q. Does it tell you if it's even a tumor or some other abnormality?

A. Opacity's purely a descriptive term.

Q. Do you recall what lateral film showed that opacity?

A. There were several lateral films that showed that.

Q. Do you recall if that opacity was present after radiation treatment?

A. Following radiation treatment the right lung is mostly obscured by fibrosis, and it's impossible to say whether the mass is still in there.

Q. Did you offer any other opinions at that second meeting?

A. I was concerned about the elevation of the right hemidiaphragm. That's one of the signs of volume loss. And at that time I wanted a radiograph obtained prior to his mediastinotomy, so I requested a baseline chest radiograph from prior to 1994.

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Q. Did they have that there at that second meeting, or is that something they had to go and get for you?

A. They had to go get that.

Q. I assume that meant that y'all met again?

A. Yes.

Q. Was there anything other than a baseline radiograph that you wanted after that second meeting?

A. At that time that was, I believe, the main focus.

Q. So when was the next meeting?

A. Probably another six to eight weeks later.

Q. Who all was present?

A. As I recall the same individuals that attended that meeting.

Q. What did you do at that second meeting?

A. I reviewed the baseline radiographs, and, again, in sequence with the subsequent films.

MR. STUHAN: Just so the record is clear, Graham, I believe you referred to this as the second meeting, although it's actually the third meeting with Dr. Chiles. Did you mean to ask about the third meeting?

MR. ESDALE: I did mean to ask about the third meeting. Thank you.

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BY MR. ESDALE:

Q. So at the third meeting they had the baseline chest radiograph that you had requested, or a baseline chest radiograph that would have been beneficial to you?

A. Yes.

Q. Do you recall the date of that?

A. I can look for it. Just a minute.

(Documents retrieved.)

The baseline chest radiographs I had were 7/22/82 and 6/12/85.

Q. Okay. And then I assume you reviewed these at this third meeting?

A. Yes.

Q. Did you re-review the other films or some other films at that time?

A. I probably would have.

Q. And what opinions did you offer based on your review of the baseline films and all the other reviews that you --

A. What I could see on the film from 7/22/82 was that there was an elevation of the right hemidiaphragm. And at that time they provided me with a history that the patient had had previous trauma. And so my interpretation at that time was

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that it was probably a paralyzed right hemidiaphragm related to his previous trauma.

Q. What other information were you furnished regarding the patient's history?

A. I knew that he'd had a mediastinotomy for a coronary bypass graft. That's all that I recall.

Q. Is there any other thing or anything else of significance of the two baseline radiographs that you've just described to me other than the elevated hemidiaphragm?

A. No. That was the most significant finding to me at that time. I guess it is also significant that although the right hemidiaphragm is elevated, the right lung base was clear at that time. And that's useful to have as a baseline.

Q. Okay. After you reviewed those - and I'm not trying to be redundant - other than the history you were given and your determination or opinions regarding the cause of the elevated hemidiaphragm, did you offer any other opinions at that time?

A. At that time I'm sure at some point during these meetings we would have talked about likely causes for the mass in the right, lower lobe.

Q. And in an effort to determine the cause of the mass, were you given any additional information

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on Mr. Acton?

A. Usually I prefer to give differential diagnosis without any subsequent histological information. I would have given my considerations, I would have been provided with additional clinical history, laboratory findings, bronchoscopic findings, and I would have used those to shape my differential if I needed to at that point.

Q. Okay. Do you recall doing any of those things at that point?

A. I don't recall the specifics of them. That's what I would have done.

Q. How did you go about formulating a differential diagnosis?

A. I'm not sure what you're asking.

Q. Well, and I might have misunderstood your answer a minute ago, but I thought you said you would have -- once you had the baselines, you probably would have moved on to try to decide the cause of the tumor.

A. Right.

Q. All right. Well, let me ask you, what would you have done an in effort to try to determine the cause of the tumor?

A. What I would have been looking at is the

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chronicity of the process.

Q. Pardon?

A. Chronicity of the process. How long the mass had been there and over what period of time it was growing. I would have also been looking for any additional findings, such as the presence of enlarged lymph nodes in the chest, the presence of plural effusion, other lesions in the opposite lung. Those are the sort of things that I would use as ancillary information to help decide what the most likely cause was.

Looking at all of the studies I felt that it was a solitary mass in the right, lower lobe, and I would have given a differential diagnosis for a solitary six-centimeter mass in the right, lower lobe.

Q. Okay. Would that have been as detailed as your differential diagnosis was, just a solitary --

A. No, that's the --

Q. -- single mass?

A. -- description. I would have given a list of possible diseases that could be responsible for that.

Q. What were those diseases?

A. Obviously with a mass of that size one

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would have to consider neoplasm.

Q. And I'm not trying to interrupt you in your answer, I just want to make sure as we go through that I understand. What do you mean by neoplasm?

A. The most likely neoplasm for this solitary mass would be a primary bronchogenic carcinoma. And I might have expected an adenocarcinoma. That would have been more likely than a large cell. It could have been a large cell carcinoma, but those are within the cell types for bronchogenic carcinoma that I would have considered.

We would have considered a carcinoid or an adenoma. We would have talked about the possibility of it being a hamartoma. We would have even considered the possibilities of benign lesions. Without the CT, if you just have the chest x-ray, might have considered even a bronchogenic cyst. So those are the types of things that one would consider and list as a differential diagnosis.

Q. Okay. Did you just provide them a list of all these types, or are these just your thought processes as you're going through this?

A. I would have probably, as I reviewed the case with them, told them what I was thinking and the diseases that I would have been considering.

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Q. Okay. What was your next step, if there was one, in your differential diagnosis?

A. Subsequently I was told about a bronchoscopy, I was told about histological information that was available and asked what was consistent with that, what was inconsistent with that.

Q. Okay. Just so I'm clear, after this third meeting, was that as detailed as your opinions were at that time, what we've just discussed as far as all the potential causes of the tumor, or the description of the tumor?

A. No. At that time we began to review clinical information, began to narrow down what the likely possibilities were.

Q. So this occurred at that third meeting after you listed these types of tumors, then you started being given some additional information?

A. That's the best I can recall. It may have been at a different meeting, but that's how I recall it.

Q. Okay. And you were told about a bronchoscopy?

A. Yes.

Q. What do you recall you were told about the

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bronchoscopy?

A. The bronchoscopist saw a small intraluminal lesion that was possibly a polyp and possibly a viral papilloma, I believe, was one of the terms that was used.

Q. Do you recall the size?

A. It was on the order of millimeters.

Q. Three, four millimeters possibly, if you recall?

A. I just remember millimeters, I don't remember a number.

Q. Did you at any time go back and review films to see if you could see the type of lesion that the bronchoscopist described?

A. Yes, I would have looked in the airways on the CT scan to see what I could see within the right, lower lobe bronchi.

Q. Did you identify any lesion that was consistent with what the bronchoscopist described?

A. The special resolution of CT that was provided was not sufficient to allow me to make that determination.

Q. So, then, you didn't see anything on the material that you had based on the films that you were given?

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A. I still show the six-centimeter mass, but I could not see airways well enough to know exactly what the bronchoscopist would have been seeing.

Q. Then is it my understanding you could not, from the CT or any other films, identify any type of small millimeter, three- to four-, five- to six-millimeter size lesion in any of the airways?

A. I felt that the bronchoscopist may have been near the lesion but not in the lesion to have made that determination.

Q. Okay. Well, then, let me just make sure I'm stating my question right. I just want to first ask you about what you were able to see on the films.

A. I couldn't see the bronchi well enough to see whether there was anything in the bronchus.

Q. Okay. So you didn't see anything then?

MR. STUHAN: Objection. That's been asked and answered more than once.

MR. ESDALE: See, I don't think it has, and I just want to make sure we're clear on the record, but ...

THE WITNESS: Well, if I can't see the bronchi, then I can't make a statement about what's in them, so ...

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BY MR. ESDALE:

Q. You had mentioned a second ago you said you thought that the bronchoscopist was near the -- I didn't understand what you said. If you could tell me that again, please.

A. The description of the bronchoscopist suggested to me that the bronchoscopist may have been near the lesion, but it was not the description I would have expected for someone who was really right in the edge of this mass.

Q. And just so we're talking about the same lesion you say may have been near the lesion, you're talking about the six-centimeter lesion mass that you've described as opposed to the polypoid lesion that the bronchoscopist described?

A. Yes. I was concerned that the bronchoscopist had not gotten far enough out at the time of bronchoscopy to adequately sample the mass.

Q. Can you explain that in a little more detail for me, please.

A. I would have expected the bronchoscopy report to have described more of a mass affect on the bronchi than was described.

Q. All right. In addition to the -- is there anything else about the bronchoscopist's report that

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you recall you're using as the basis for any of your opinions?

A. No.

Q. All right. What other information were you given at this meeting to allow you to go through the differential diagnosis?

A. At some point I would have been told about the survival of the patient and how the patient was treated.

Q. And what were you told about the survival of the patient?

A. That the patient was still alive.

Q. Anything else other than that that was significant to you in formulating your opinions?

A. There may have been but that's all I can recall right now.

Q. And how the patient was treated?

A. Yes.

Q. What do you recall about how the patient was treated?

A. I believe he received both radiation therapy and chemotherapy.

Q. What was significant about the treatment?

A. The significance is that the radiation therapy produces tremendous change in appearance of

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the chest x-ray and of the CT.

Q. Anything else?

A. That's the main consequence of the radiation therapy from my perspective.

Q. Were you given any other information at that meeting?

A. I may have been but that's all that I can recall right now.

Q. Do you know why the patient would have been given radiation/chemotherapy?

A. The patient had a presumed diagnosis of a malignancy.

Q. Do you recall what the malignancy was?

A. Small cell.

Q. Were you also given that information at this meeting?

A. Yes.

Q. How did you use that information in formulating a differential diagnosis?

A. Well, what I would do then is look and see are the images I'm looking at compatible with that diagnosis. And I did not feel that the imaging studies that I had were compatible with that diagnosis.

Q. Why not?

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A. There was no evidence of lymphadenopathy in the chest, and one would expect small cell that reached the size of six centimeters to have already spread to lymph nodes within the mediastinum and hilum.

Q. Okay. Anything else?

A. At that time I had no clinical evidence and no imaging evidence of metastases to the adrenal glands or liver or brain, which is where I might expect to find metastatic small cell.

Q. Okay. Anything else?

A. Can you ask me your question again?

Q. You told me that you didn't think that the imaging studies were compatible with I assume a diagnosis of small-cell lung cancer.

A. Yes. Also the survival of the patient was a factor in that the patient was surviving longer than one would expect for small cell.

Q. Are there any other areas that you can think of that were incompatible?

A. Those are the key areas.

Q. Are there any others that you plan on discussing at the trial of this case?

A. I might but that's all I can think of right now.

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Q. Once you determined that the imaging studies weren't compatible with small cell, did you try to, based on the information you had, make the determination as to what type of tumor it was, or mass?

A. Yes.

Q. How did you go about that?

A. Well, one would want to consider types of tumors that could be mistaken for small-cell carcinoma histopathologically. And the tumor that is most likely to be mistaken for small cell would be a carcinoid.

Q. And you say histopathologically, are you talking about --

A. A pathologist looking at cellular material.

Q. All right. Can you give me generally the characteristics of a carcinoid?

A. The imaging characteristics, or?

Q. Well, we'll start with those. That will be fine.

A. A carcinoid on a chest x-ray would likely be a solitary mass. It could be either peripherally located within the lungs. It's usually a fairly well-defined solitary mass. It can also present more centrally, and can present with chest x-rays showing

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lobar collapse or even air trapping.

Q. What is lobar collapse?

A. Collapse is when the bronchus of that lobe is occluded and the entire lobe loses all the air that's in it.

Q. What about size?

A. The size is variable.

Q. Do you have any way of characterizing the median or mean size of carcinoids?

A. There may be an average size but it's such a wide spectrum that it really wouldn't be of much value to me.

Q. So you don't look at the majority of carcinoids are found in a certain size, or if they are that has no bearing?

A. I wouldn't look at a lesion and say this is either too large or too small to be a carcinoid.

Q. Have you on other occasions x-rayed abnormalities that were since determined to be carcinoid?

A. I don't do the x-rays but I would have interpreted the x-rays as a lesion that could potentially be a carcinoid, yes.

Q. And you've done that on other occasions?

A. Yes.

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Q. How many occasions have you interpreted the x-rays that were carcinoid tumors of the lung?

A. Individual cases?

Q. Yes.

A. We would see five or six a year in my department. I might be involved in each of those at some point but perhaps not in the initial diagnosis.

Q. And these are carcinoids of the lung?

A. Yes.

Q. Do you have any information as to what percentage of all lung tumors carcinoids comprise?

A. No.

Q. Would that make any difference to you in your diagnosis, differential diagnosis?

A. One considers the relative frequency of lesions as you rank your differential diagnosis. Certainly lesions that are more frequent might be ranked higher in the differential, but you're not going to exclude something just because it's not as common.

Q. Have you ever seen any published information on the frequency of carcinoids in the lung as compared with other tumors of the lung?

A. I have. I don't remember the statistics off the top of my head.

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Q. Would it make any difference to you if they were 1 percent?

A. It would still mean to me that that patient might have a carcinoid.

Q. All right. Did you do any other additional work as far as your differential diagnosis? We kind of left off, you were telling me about the areas you looked at.

A. That's the main thing, as I recall, in discussing the case and determining what was the most likely diagnosis.

Q. Did you consider any other types of tumors other than the carcinoid?

A. I might have considered bronchial adenoma. I would have considered sarcomas arising within the lung.

Q. Was it your opinion then that this third meeting that the mass that you saw on the films was in fact a carcinoid?

A. At that time I felt that it was unlikely to be a small-cell carcinoma, and I would have ranked carcinoid higher on the list of the differential.

Q. Was there anything ranked higher than carcinoid?

A. At that time knowing that it had -- that

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the question of small cell had been raised by the pathologist, I felt that carcinoid was most likely.

Q. Have you ever provided a diagnosis of tumors for treatment purposes?

A. I don't understand your question.

Q. In other words, I mean have you ever reviewed films, history, bronchoscopy reports, things of that nature, and then provided to another doctor a diagnosis of a tumor for treatment purposes?

A. At my institution no tumor would be treated without histological confirmation.

Q. Do you routinely provide diagnostic information as far as tumor types to other physicians?

A. Yes. If I see a mass that has characteristics that are highly suspicious of a squamous cell carcinoma, I would list that as a likely scenario.

Similarly, if a patient has a known malignancy -- let's say if a patient has a known osteosarcoma and I see multiple nodules in the lungs, I would say these are likely metastatic osteosarcomas. So, yes, I would tend to suggest definitive diagnosis.

Q. Can you go through the films that you're

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relying on for your opinions?

A. Yes.

MR. ESDALE: Do you want to take a break?

MR. STUHAN: We've been going about an hour. Let's take a five-minute break.

(Recess taken.)

BY MR. ESDALE:

Q. Well, let's just go ahead and go through the x-rays, if we can, and I'm including in that CT's and bone scans, everything that you reviewed, and if we can do it in chronological order, if that's all right. But you can do it however is easiest for you to express what you viewed, why you viewed it, and what your opinions of them were.

MR. ESDALE: Off the record for a second.

(Comments off record.)

(Plaintiff's Exhibits 3-A & 3-B were marked for identification.)

BY MR. ESDALE:

Q. What are those?

A. PA and lateral chest x-ray dated 7/22/82.

Q. Okay. This was from '82?

A. Yes.

Q. And these were the baseline --

A. Yes.

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Q. -- chest radiographs that we discussed earlier?

A. Uh-huh.

Q. What, if anything, is significant about these?

A. This was significant in that the right hemidiaphragm was abnormally elevated. On one film it would be hard to draw any conclusions from that, but by reviewing them in sequence with the other films you can see that this persists.

I was provided information that he had had a motor vehicle accident in the past, and my conclusion was that this most likely represented paralysis of the hemidiaphragm due to the previous trauma.

Q. Anything else from 3-A and B?

A. That's the only abnormality that I see on that film.

Q. Okay. Let's move on to the next one. Let me ask you a question while you're doing that. I assume that by the only abnormality that the fact that there were no other abnormalities is something that you're using as the basis of your opinions also?

A. Yes.

Q. How many films are in this next packet?

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A. Two. These are dated 6/12/85. This is a PA and lateral.

Q. Dr. Chiles, let me go ahead and give you 4-A. If we can be consistent and use the A's for the PA's and the B's for the lateral.

(Plaintiff's Exhibits 4-A & 4-B were marked for identification.)

All right. What are significant about these?

A. At this time he has already had his mediastinotomy for his coronary bypass grafting. We can see that the right hemidiaphragm remains elevated. But otherwise the lungs are clear.

Q. Anything else about these?

A. No.

Q. Okay.

(Plaintiff's Exhibits 5-A & 5-B were marked for identification.)

5-A and 5-B, these are what?

A. This is a PA and lateral dated 2/4/94.

Q. What is significant about these films?

A. At this point if one compares this frontal chest radiograph to the chest radiograph approximately nine years earlier there is --

Q. Let's talk -- and I'm sorry to cut you

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off. Let's use exhibit numbers so it would be clear on the record. If we're comparing --

A. 5-A to 4-A you can see that there is increased opacity in the medial aspect of the right lung base compared to the prior study.

Q. Okay.

MR. ESDALE: Hold on a second before you take these down. Do you think a highlighter would mark on these things?

THE WITNESS: It would never come off.

MR. ESDALE: It will stay on there?

THE WITNESS: Yeah. I wouldn't use anything other than a wax pencil. A crayon would work.

MR. ESDALE: Have you got any crayons, Jonathan?

MR. ENGRAM: No.

MR. ESDALE: I'm just wondering, we're going to have to mark these some way, I think, so we can see what she's describing. I mean, I don't care if it doesn't come off, but if it's going to mess y'all's radiographs up ...

(Off the record.)

MR. STUHAN: Before you start, Graham, Dr. Chiles has had her current curriculum vitae faxed

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to us here and I have a copy of it which I will make available to you at this time.

MR. ESDALE: Okay.

MR. STUHAN: It's entirely up to you whether you want to mark it.

MR. ESDALE: And I will. Just set it down. I'll do it in a minute. We'll go ahead and do these x-rays.

BY MR. ESDALE:

Q. All right. You had mentioned some opacity?

A. Uh-huh.

Q. Can you point out with the marker what you're speaking of?

A. Yes. I would call that (indicating) area as more opaque than on the previous.

Q. What significance does that have, if any, to you?

A. At that point some things I'd be considering would be atelectasis or volume loss in that area, it could be pneumonia in that area. Those are the main things I would be considering at that time. It would be affected by why this chest x-ray was obtained, whether the patient was symptomatic.

Q. Did you ever receive any information as to why 5-A was obtained?

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A. I probably had x-ray reports at some time that would have had that, but when I was first reviewing the film I don't believe I had the reason for the examination.

Q. Do you have an opinion as to whether or not that's a mass based on your review of 5-A?

A. At this point I think that mostly what I'm seeing is volume loss.

Q. And that means what?

A. That there's some obstruction to the airway, which could be either transient or permanent, and there is a loss of air from the air spaces distal to that obstruction.

Q. Does pneumonia look like that at times also?

A. Pneumonia can be predominantly characterized by volume loss sometimes.

Q. Anything else about 5-A?

A. On the lateral -- I think that the area that I'm looking at on the lateral is right here (indicating). There's just more crowding of the vessels so I'm concerned about volume loss.

Q. Okay. There's three films in that one?

A. Yes.

(Plaintiff's Exhibits 6-A & 6-B were marked for

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identification.)

Q. There's 6-A. All right. These are dated when?

A. These are dated 6/1/94.

Q. All right. And 6-A is a PA?

A. Yes.

Q. And 6-B is?

A. A lateral.

Q. All right. What is significant about these two?

A. These chest x-rays continue to show an area of volume loss in the right lung base, which we can see here (indicating) adjacent to the right heart boarder. The right heart boarder has changed.

Q. Can you kind of outline the heart boarder, please?

A. Yes. The right heart boarder has changed in configuration. There's now a bulge extending from the lateral aspect of the right heart boarder. And it's difficult to know on this film whether that represents the edge of a mass or whether that could be the heart boarder itself.

Q. What about the lateral?

A. On the lateral there is some blurring due to respiratory motion, but you can see a somewhat

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nodular opacity on the lateral radiograph which is right in this (indicating) area of volume loss.

Q. Okay. When you say "nodular opacity," do you have an opinion as to what the opacity represents, if anything?

A. In general or as it relates to this specific film?

Q. As it relates to that specific film.

A. At this time I'm concerned that this is the tumor that we see subsequently on CT's and on follow-up chest x-rays.

Q. What about generally?

A. In general, any time I would encounter a nodular opacity, I'd be concerned about tumor or infection or varix or AVM. There's a whole list of things that could produce a pulmonary nodule.

Q. Is there anything else significant about 6-A or 6-B?

A. Those are the main changes from the prior study.

Q. Is there another one in there?

A. What happened is that when they obtained one frontal chest radiograph the right costophrenic angle was not included on the film, so the technician went back and obtained a second film to include the

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right level costophrenic angle.

Q. Okay. Let me go ahead and mark that second film just so we would be accounting for everything. 6-C.

(Plaintiff's Exhibit 6-C was marked for identification.)

Does it also show the same opacity that 6-A does?

A. Yes, but not as clearly. It's a darker film. The copy's not as good. I don't think it's as clearly seen on this one as on 6-A.

Q. Okay.

(Plaintiff's Exhibits 7-A & 7-B were marked for identification.)

Okay. What is 7-A and 7-B?

A. This is a PA and lateral dated 2/2/95.

Q. All right. What's significant about these?

A. These chest radiographs clearly show an opacity in the right, lower lobe. There's a mass-like opacity seen on the frontal examination, and there is a more triangular opacity seen on the lateral examination.

Q. Could you go ahead and continue with the lateral? It just looks like you've drawn just two sides. You said a triangular, I'm trying to figure

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out --

A. Right. Okay. And then it merges with the diagram. So it would be like that (demonstrating).

Q. Okay. All right. All right. And the significance of these, they're just what?

A. The significance is that I'm suspecting that there is a mass accompanied by significant volume loss in the right, lower lobe.

Q. Do those in combination -- or are there changes taking place between 6-A and B?

A. Yes.

Q. And 7-A and B?

A. If we go back to 5-B where there is early evidence of volume loss, we can see that this has progressed over this one-year interval. And so my concern is that there is a tumor that is growing in the right, lower lobe over a one-year interval.

Q. And are the opacity becoming -- I don't know the term to describe it, the changes, is that why you're saying -- or just tell me why -- specifically what are the changes to -- that are depicted on 7-A and 7-B that are leading you to be more firm in your opinion.

A. There is progression. The mass is more likely seen, and there's more volume loss than was

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present a year earlier.

Q. Okay. Anything else of significance about 7-A or B?

A. There are pertinent negatives in that the hilum and the mediastinum are made normal. There's no evidence of adenopathy, there's no evidence of plural effusion, and it's a solitary lesion confined to the right, lower lobe.

Q. Show me where you would expect to find lymph node problems.

A. A mass in the right, lower lobe would spread to the right hilum lymph nodes first. It might also go to subcranial lymph nodes. And so where I would look on the right hilum, one area is on the lateral radiograph. And you can see this little, thin white line here which is the posterior wall of the bronchus intermedius. As you come down the trachea the right bronchus comes off from the trachea at the bifurcation of the corona. First the right upper lobe bronchus is taking off and this (indicating) is the bronchus intermedius. And this is the bronchus that's taking air down to the right, middle and lower lobes.

Q. Okay.

A. The posterior wall of the --

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Q. That's all right, you can leave those on there if it's all right with you.

A. The posterior wall of the bronchus intermedius is outlined by air in the bronchus interiorly and air in the lung posteriorly. Lymph nodes that grow behind here (indicating), which is where I would expect this tumor to spread, would cause thickening or lobulation or some abnormality of the contour of the posterior wall of the bronchus intermedius. But that is exquisitely normal in this patient. And that's very reassuring to me that there is no hilum lymph adenopathy. That's where I would look on the lateral examination.

On the frontal examination I see a normal somewhat Y-shaped configuration of the pulmonary arteries. There's no lobulation, there's no extra opacity to them, and so the hilum looks normal to me.

Q. Okay.

(Plaintiff's Exhibits 8-A & 8-B were marked for identification.)

All right. What have we got here?

A. This is 8-A and B. This is a PA and lateral chest radiograph dated 4/4/95. So this is two months after the previous x-ray.

Again we see evidence of volume loss within

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the right, lower lobe. On 8-B, the lateral examination, we can again see a triangular opacity which is larger than it appeared on the prior examination. And this represents collapse of some of the segments of the right, lower lobe. The entire right, lower lobe is not collapsed, but some of the segments of the right, lower lobe are.

On 8-A, the frontal radiograph, we can see a somewhat mass-like opacity at the right lung base. So, again, my concern is that there has been progression in the size of the mass and progression in the atelectasis associated with this mass since the prior examination.

Q. Okay. Did you attempt to measure the mass based on any of the lateral and PA chest x-rays?

A. You can attempt to measure it but it's not an accurate measurement because of the adjacent atelectasis.

Q. Okay. What about with the CT?

A. The CT of the mass is much more readily measured.

Q. Okay. I assume that's coming up.

How many films do we have?

A. Just the ones we want to see, or do you want to label every one of them?

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Q. Well, just the ones that you used to formulate your opinions.

MR. STUHAN: Do you want to limit yourself, Graham, to the chest CT's and not have her take account of the abdominal CT's which I believe are also in that envelope?

MR. ESDALE: What type, abdominal?

MR. STUHAN: Abdominal CT's.

MR. ESDALE: Yeah. I'm not going to mark those unless they're of some significance to them.

THE WITNESS: Four. We're just going to use these four sheets. There's another scan in this packet which is not visible.

MR. ESDALE: All right. But there's only four sheets that you're using.

(Plaintiff's Exhibits 9-A & 9-B were marked for identification.)

BY MR. ESDALE:

Q. What is 9-A?

A. 9-A are the lung windows from the CT scan of the chest dated 4/10/95.

Q. And is that the same, just continuation for 9-B?

A. 9-B continues the lung windows but also includes the scout views and annotated scout, and

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there are some cone down views of the thorax which have been annotated presumably by the CT technologist.

Q. Okay. Tell me what's significance about 9-A.

A. 9-A shows a rounded, lobulated mass in the right, lower lobe. It measures approximately six-by-five centimeters. And I can mark it here (indicating).

Q. Okay. And that is on what cut?

A. It's seen best on image number 16.

Q. Okay. And you said the size of it is approximately what?

A. Six-by-five centimeters.

Q. When you say six-by-five, tell me which direction are we going in for those measurements?

A. I measure the longest axis, and then I measure the axis that's perpendicular or cognate to that axis. So I measure in this (indicating) axial two-dimensional view.

Q. So we're measuring depth and width?

A. Yes.

Q. As opposed to height if we're talking about a person standing upright?

A. Yes.

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Q. All right. And what is the six -- you say "sonometers," am I just mispronouncing centimeters, or have we just got a regional dialect situation on our hands?

A. I think it can be pronounced either way.

MR. STUHAN: You say "tamoto," I say tomato.

MR. ESDALE: Okay. I just want to make sure -- I'm sure I'm butchering the medical language if there is such thing.

BY MR. ESDALE:

Q. Anyhow, which is the six centimeter?

A. I measured the six centimeters in the longest axis so it's not exactly depth.

Q. Okay.

A. And then I would measure five centimeters in orthogonal. I go for the longest axis regardless of whether it's the X or Y axis.

Q. Okay. Now do you have the ability to measure the height based on the CT?

A. It's difficult on this scan because of respiratory motion. If the patient changes the depth of inspiration, it can make the mass look larger or smaller. So one could measure it but it might not be an accurate measurement.

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Q. Do you mind doing that for me with that qualification on there? Can you tell me where you first start seeing the mass and then where you think it ends?

A. I first started seeing the mass on image number 14, and I do not see -- it's hard to know where the mass stops and where the atelectasis starts. So I see atelectasis clearly extending through 21 and 22, but the mass may have stopped at image 18.

Q. Okay. All right. Anything else of significance about the CT?

A. These windows and the mediastinal windows also showed that there's no plural effusion, there's no adenopathy, that it is a solitary lesion.

Q. When you say "the mediastinal windows," show me which one you're talking about.

A. Those are the next ones.

Q. Okay. Is there anything else before we move on, anything about 9-A or B other than what we just talked about --

A. No.

Q. -- that's significant to you in your opinions?

A. Not to me.

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Q. Here, I'm going to give you these again.

(Plaintiff's Exhibits 9-C & 9-D was marked for identification.)

And 9-C and 9-D are what?

A. These are mediastinal or soft tissue windows. They're the same images that we just saw but they're filmed with different windows and level settings.

Q. And tell me what is significant about C and D to you.

A. These images again show the mass. We can see here on image number 16 that it's a solid mass. If I were to measure the attenuation values of that mass and that tells us -- we have attenuation values to distinguish fact from air, from water to bone, from soft tissue, and this mass, the attenuation values are very similar to muscle. If one compares the mass to the muscles in the chest wall, it's a fairly similar attenuation. So this I would call a soft tissue mass. I don't see any evidence of necrosis or cavitation.

Q. All right. Let me ask you, if there were any bone in that mass would it show up on one of these mediastinal films?

A. If there was a sufficient quantity of bone

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it should show up, yes.

Q. Okay. Is there any way to quantify what you're meaning by sufficient quantity?

A. No, not on this. These are 10-millimeter slices, and how much bone would be necessary would be different according to whether you had a one-millimeter slice or a 10-millimeter slice. So I really couldn't come up with any sort of quantity.

Q. Okay. Have you ever seen bone in carcinoids before?

A. No.

Q. All right. What slice is that, or section?

A. That's image number 16.

Q. All right. Those correspond with the 9-A and B that we just looked at?

A. Yes.

Q. And would the same be true as far as if you were trying to look at the height of this mass? Is this going to show it any more clearly than 9-A and B did?

A. No.

Q. Would your answer be the same then from where you basically see it, starting and then kind of losing it at the end?

A. Yes.

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Q. Okay. Anything else of significance about C or D?

A. This is the study that really helps you be quite certain that there is no hilum mediastinal adenopathy.

Q. Okay. All right.

A. Those are the images that I find that I based my opinions on.

Q. Okay. I'm going to go ahead and mark the updated CV as 10.

(Plaintiff's Exhibit 10 was marked for identification.)

Dr. Chiles, have you ever been involved in the treatment diagnosis of small-cell lung cancer patients before?

A. Yes.

Q. Have you ever had the occasion to be involved with a small-cell lung cancer patient who did not have mastosis?

A. Yes. Small cell may be confined to the thorax.

Q. In a single mass?

A. It can be as a solitary mass, but not of this size.

Q. So you've never been involved with a

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small-cell lung cancer patient with a five- to six-centimeter mass that did not have mastosis?

A. Yes. I would expect them to have mastosis at least to regional lymph nodes.

Q. And let me make sure I'm just clear on my question. Then you have never been involved with treatment or otherwise of small-cell lung cancer patients that had a five-centimeter or larger mass that did not have mastosis?

A. That's correct.

Q. All right. I'm going to go back through some of your opinions other than what you've already told me. It says in your expert disclosure that you may be called on to comment on matters raised in the testimony of other witnesses as they relate to your area of expertise. Have you been provided with the testimony of any other witnesses?

A. No.

Q. I assume then, as we sit here today, at this time, you don't have any criticisms or comments on the testimony of any other witnesses?

A. Not at this time.

Q. It says you'll testify regarding the techniques, procedures and criteria used by radiologists to diagnose diseases, including cancer.

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Is there anything that we haven't already discussed that you plan on testifying about regarding the techniques, procedures and criteria used by radiologists?

A. I might be asked questions that we haven't discussed today. So I would have to say I might be asked questions that I would provide answers to.

Q. Well, let me ask it this way, is there anything regarding the technique, procedures and criteria used by you to diagnose the mass in this case that we have not discussed?

A. That I used, or that were used by the people involved in the care of the patient? I'm not sure I understand.

Q. Well, do you have any -- well, let's do it both ways. I'll ask the question first that you used.

A. Could you restate the question, please?

Q. Sure. Are there any techniques, procedures and criteria that you used to formulate an opinion on the mass in Mr. Acton that we have not already discussed today?

A. Well, we really didn't discuss the rate of growth. I was sort of alluding to that when we reviewed the sequence of films. But the rate of

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growth of a lesion is something that I would use in formulating my opinion about the most likely diagnosis. So that's something we really didn't touch on yet today.

Q. How would you classify the rate of growth of your opinion of the mass in the films that you've reviewed in this case?

A. This mass was growing over at least a year.

Q. Would you classify that as a slow-growing mass?

A. It is not as slowly growing as some. I've seen tumors that grow more slowly than that, but it's certainly not a fast-growing tumor.

Q. Do you have any way of comparing this, that is your opinion, as a carcinoid with any carcinoids that you've had any experience with in the past?

A. The carcinoids that I've seen have not been fast-growing tumors, so I think that this rate of growth is consistent with carcinoid.

Q. The other carcinoids then that you've been involved with grew at about the same rate?

A. It's a wide spectrum and sometimes we don't get much information about rate of growth. As soon as we identify the lesion, it's surgically resected. So you don't often spend a lot of time watching it

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grow.

Q. Have you ever had any experience with carcinoids that were five or six centimeters in size, carcinoids of the lung?

A. Yes.

Q. On how many occasions?

A. A couple of times.

Q. Is it rare?

A. It's not something I see every day.

Q. Now you, a minute ago, drew a distinction between the techniques, procedures and criteria that you used and the ones that the treating physicians used?

A. Yes.

Q. All right. What opinions do you have regarding the techniques, criteria and procedures used by the treating physicians in this case?

A. Well, in some circumstances if the bronchoscopy specimen is inadequate I might do a transthoracic needle aspiration of a mass to get more adequate tissue sampling. So there's some other issues like that that we really haven't gone into that I use on a routine basis for suspected lung cancer.

Q. Have you ever treated any patients with

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lung cancer?

A. What do you mean by treatment? Do you mean radiation therapy or --

Q. Do you perform radiation therapy?

A. No.

Q. Do you perform or administer chemotherapy or anything like that?

A. No. I do some procedures that can be called therapeutic though.

Q. And what would those be?

A. If a patient has malignant plural effusion or empyema I might be asked to place a plural drainage catheter and that would be considered a therapeutic procedure.

Q. And when you say "place a catheter," are you working with the assistance of a surgeon?

A. No.

Q. Or you actually placing the catheter yourself?

A. I place the catheter myself.

Q. Also something I need to clear up too, as far as do you have any certifications or licensures other than in radiology?

A. No.

Q. Are you going to offer any opinions or do

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you plan on offering any opinions in any fields other than radiology?

A. I'm not sure what you mean by that question. Some of the questions you've asked are not always radiology questions but I felt compelled to answer them.

Q. Sure. And I appreciate that. I just didn't know if you had any plans to offer opinions regarding pathology or pulmonology or anything, any other fields of expertise.

A. When I encounter a patient with suspected lung cancer I work closely with the pulmonologist, and with oncologists and with a pathologist, and so I might offer opinions on how that relationship and how that communication and how the transfer of information happens.

Q. Okay. How does that happen in your day-to-day activities?

A. If I encounter a study that I think is consistent with neoplasm, I'd be talking with the clinician, I might be asked to do the biopsy. I would biopsy the lesion, I'd provide material to a pathologist, the pathologist would review the material with me, and we would decide if we have sufficient material to establish a diagnosis. So

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those are the sorts of things -- the radiation therapist might come to me and ask my help in outlining the tumor and a radiation port. So I'm involved in a team that takes care of the patient.

Q. Have you ever worked in rural areas?

A. Yes.

Q. Does that differ any in the procedures you just discussed with me as opposed to working in a hospital?

A. In some hospitals the pathologist is not on site at the time of the biopsy. And in some areas biopsy in this case might be done under fluoroscopy rather than being CT guided. Those are some of the differences one might encounter.

Q. Tell me what you mean by fluoroscopy as opposed to CT guided.

A. Fluoroscopy uses an x-ray beam but it does not use the CT scanner. So you don't have the computer that gives you the three-dimensional images. You're really just looking at a two-dimensional image.

Q. Okay. And this is something that's going on at the same time; for instance, in this case the bronchoscopy?

A. Yes.

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Q. Do you have any criticisms of the way any of that was performed based on what knowledge you have today?

A. The bronchoscopists that I work with are pulmonologists and that's -- most of the bronchoscopy of the patients I see is performed by a pulmonologist.

Q. And do you know if Dr. Perrett is a pulmonologist or not?

A. I do not.

Q. I want to touch real quickly on, you mentioned earlier you thought the pulmonologist might not -- or the bronchoscopist might not have gone far enough. I know that's paraphrasing. Could you explain that to me again?

A. The bronchoscope is limited in its ability to look into the small bronchi of the lung. One might get out to segmental bronchi but might not get past that level with a bronchoscope. There are geographic limitations on how far out into the trachea bronchial tree that the bronchoscopist can see. And so for peripheral lesions we prefer, at my institution, to access those with a transthoracic needle aspiration. So my concern here would be, did the bronchoscopy reach the lesion, or might it be

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better reached by transthoracic needle aspiration.

Q. All right. Do you have some questions in your mind then whether - just the way I understand this - the bronchoscopist even actually reached the lesion?

A. I think he reached the very tip of the lesion, but I don't think he was in the center of it.

Q. Do you think it was protruding through the wall of the bronchus?

A. There may have been a small component that protruded through the wall of the bronchus.

Q. And do you think that's what he got?

A. I think that's what he got.

Q. Okay. It says here that it's your opinion that Mr. Acton had a single lobulated, rounded lung mass in the right, lower lobe more likely than not present since June of 1994. Is there anything about that statement or any basis of your opinions that we haven't already discussed?

A. Not that I recall.

Q. I mean, you've showed me the -- on the x-rays -- well, let me ask it this way. Does it appear on the CT or can you tell through just the regular chest x-rays the fact that the mass is well-rounded as opposed to spiculated or irregularly

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shaped?

A. Could you ask that question again, I'm sorry?

Q. On the chest x-rays can you tell based on those if the mass is well-rounded or not?

A. The mass appears well-rounded but because of the adjacent atelectasis I can't make that determination with as much confidence as I can on the CT.

Q. And earlier we had looked at a slide or section 16 as the one that you circled showing that that would be the best example of the best slide depicting a mass. Is that one of the slides that you're relying on that you claim shows the well-rounded portion of the mass?

A. Yes.

Q. What would you expect a spiculated or not well-rounded mass to look like on the CT?

A. That would best be appreciated on the lung window settings, and one would see irregular or needle-like protrusions that extend from the margin of the mass.

Q. Oh, you know one thing we didn't look at, and I don't know how much they play, based on what you told me they don't, but I just want to make sure

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we haven't missed something, that is the bone scans. Earlier you said those were all the films that you used for your opinions. Are you not relying or don't plan on relying on the bone scans at trial?

A. I don't plan on relying on bone scans.

Q. Okay. Just going on here it says it's your opinion, based on the available radiology which we've looked at, the medical history, and the clinical course, it's your opinion that this mass more likely represents a carcinoid than a small-cell lung carcinoma. Is there anything we haven't talked about as far as differential diagnosis that leads you to that opinion?

A. That's all I can think of right now.

Q. "It says carcinoid growth such as Dr. Chiles believes Mr. Acton had have not been statistically associated with exposure to cigarette smoke." What are you basing that opinion on?

A. My reading and familiarity with the literature.

Q. Is there any specific literature or just open literature?

A. Just open literature.

Q. Are there any, in your opinion, types of lung tumors that are associated with exposure to

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cigarette smoke?

A. Yes.

Q. What types?

A. Small cell has been linked with cigarette smoking as has squamous cell.

Q. When you say "small cell has been linked," do you have any opinions as to whether cigarette smoke causes small-cell lung cancer?

A. At this point I don't think it's completely understood. There's an association about the cause, and effect is not completely understood.

Q. Have you ever been involved with the treatment or care of a patient who had lung cancer that was caused by cigarette smoke?

A. I've been involved in the care of patients who had lung cancer who are cigarette smokers, yes.

Q. But you don't have any opinion as to whether the cigarette smoke caused their lung cancer or not?

A. It's hard to know with 100 percent certainty.

Q. Do you have an opinion, based on a reasonable degree of medical certainty, whether any patient you've ever been associated with that had lung cancer was caused by cigarette smoke?

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A. I certainly see a lot of lung cancers in cigarette smokers and there's a very high association. Cigarette smoking clearly plays a role, but how the tumor gets started, I don't completely understand.

Q. Are there any specific publications or articles or text that you plan on relying on?

A. Not specific articles or text, no.

Q. You mentioned earlier in doing a differential diagnosis of an abnormality you would characterize it, consider the course, and then make a list of the most likely etiology. What do you mean by that?

A. I use that term interchangeably with diagnosis. Etiologies would include categories of disease such as congenital lesions, infectious lesions, traumatic lesions, vascular lesions, neoplastic lesions. So that's just -- by etiology I mean those categories of disease processes.

Q. Have you consulted with any other doctors regarding this case?

A. No.

Q. Have you consulted with anyone other than the attorneys in this case regarding this case?

A. No.

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Q. All right. Let me just take a second and look at these two CV's.

(Comments off the record.)

BY MR. ESDALE:

Q. All right. Just so we're clear, I'm trying to understand this, it's my understanding the most recent CV has been, in addition to the font being changed, reconfigured also?

A. I think the journal articles are placed in a separate section than their presentations. It was a hospital-wide change in how CV's were configured. The information should be all there on both of them.

MR. STUHAN: Are we off the record?

(Comments off the record.)

(Plaintiff's Exhibit 11 was marked for identification.)

MR. ESDALE: Well, I'm not going to try to go through all these right now. If there's something that crops up we can address it before trial.

MR. STUHAN: Are you done?

MR. ESDALE: Yes.

MR. STUHAN: I have a few questions.

EXAMINATION

BY MR. STUHAN:

Q. Dr. Chiles, you testified that you were not

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relying on the bone scans in formulating the opinions that you intend to express at trial; is that correct?

A. That's correct.

Q. Your disclosure statement indicates that you may be called upon to comment on matters raised in the testimony of other witnesses. And since some of the other witnesses in this case, particularly on the plaintiff's side, have raised the matter of the bone scan, I'd like to spend a couple of minutes with you on those bone scans.

First of all let me ask you, have you reviewed the bone scans?

A. Yes.

Q. Do you recall how many of them there were?

A. There are four.

Q. Can we put the earliest in time of those bone scans on the view box.

(Witness complied.)

Doctor, let us mark the bone scan that you've put on the view box as Defendant's Exhibit Number 1 for identification.

(Defendant's Exhibit 1 was marked for identification.)

When was this bone scan taken, Doctor?

A. 4/19/95.

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Q. And can you tell us what you see on that bone scan?

A. You see normal uptake in the axial skeleton. There is a little activity in the urinary bladder. There are some areas of increased activity, particularly within the left knee and in transverse process of one of the upper thoracic vertebra, which I would interpret as degenerative in origin.

Q. Do you interpret any of those areas of increased activity as a neoplastic process?

A. No.

Q. Do you interpret any of those areas of increased activity as representing metastatic disease?

A. No.

Q. Would you kindly put on the view box the next bone scan in time taken on Mr. Acton. We'll mark it for identification as Defendant's Exhibit 2.

(Defendant's Exhibit 2 was marked for identification.)

Dr. Chiles, would you describe what you see on Defendant's Exhibit Number 2?

A. At this time we again see uptake in the axial skeleton. There is residual activity within the collecting systems of both kidneys and again

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within the urinary bladder because isotope is excreted by the kidneys. We also see a new area of increased activity within the right, lateral, lower chest wall, and I believe that these are within two lower ribs, possibly the lateral aspects of the right eighth and ninth ribs.

Q. How would you describe the area of increased activity that you see in the area of the eighth and ninth ribs?

A. It's hard to tell for certain without additional cone down or opaque views, but I think there are two separate areas of increased activity in two adjacent ribs. If I see a lesion in two adjacent ribs, I would interpret that as being probably traumatic in origin.

Q. When you say "traumatic in origin," what do you mean by that?

A. If the patient had fallen and bumped his lower chest against the kitchen counter or a door knob or anything like that, it could have resulted in injury to those ribs and that would cause an increased activity on a bone scan.

Q. How severe would the traumatic injury have to be in order to result in positive read on a bone scan?

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A. It really just has to cause some bruising within the rib. It doesn't have to completely fracture the rib, it just has to cause some bruising.

Q. How would you describe the shape, the morphology of the area of increased uptake in the eighth and ninth ribs?

A. It appears confined to the ribs. It seems to travel in the plane of the rib.

Q. Let me ask you a general question about bone scans as a radiologic technique. Are bone scans sensitive?

A. Yes. It's a very sensitive examination for any abnormality within the bone but it's not specific. So if I see increased activity then it could be due to trauma, it could be due to arthritis, it could be due to metastatic disease, it could be due to infection. It just simply localizes the abnormal area for us. So sensitive but not specific.

Q. The term "sensitive" means what?

A. That out of -- let's say we had 100 patients with any abnormality, it would pick a large number of those patients. It would have few false-negatives.

Q. And what does the term "specific" mean?

A. Specific means that if I'm looking for a

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specific diagnosis it would have true-positives but it would not have false-positive. I hope I'm getting this correct. But the way I'm using that term here is that by being nonspecific it can't tell us which of those disease process is at play for this study.

Q. Would it be fair to say that a process or technique that's sensitive but not specific is useful in identifying abnormalities but not in telling you what the nature of those abnormalities are?

A. That's correct.

Q. Would you put on the view box the next bone scan in time. We'll mark it for identification as Number 3, Defendant's Exhibit 3.

(Defendant's Exhibit 3 was marked for identification.)

Would you identify, Doctor, this bone scan.

A. This is dated 5/13/96.

Q. And what do you see on the May 13, '96 bone scan that's been marked for identification as Defendant's Exhibit 3?

A. There is a new solitary focus of increased activity. And, again, it's within a right posterior lateral rib, but it's in a different location than was on the prior study. To me I think it's in the

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seventh rib, and I think it's in a little bit more posterior location, and the lesions that I saw previously I don't see any longer on this study.

Q. When you say the previous lesions are you referring to the area of increased activity that you identified in the eighth and ninth ribs on what we marked for identification as Defendant's Exhibit 2?

A. Yes.

Q. Now the record in this case will show that sometime after the December 1995 bone scan was taken, that's Defendant's Exhibit 1 for identification, Mr. Acton received palliative radiation. Could palliative radiation have made that area of increased activity that you saw on Defendant's Exhibit 2 in the eighth and ninth ribs go away?

A. No.

Q. Why not?

A. If that had been a tumor I would expect it to show still activity subsequently, and in fact radiation can cause increased activity within the bone. The fact that it is resolved to me means that it was most likely traumatic and there's a spontaneous resolution.

Q. To your knowledge, Dr. Chiles, did Mr. Acton have any therapy, either radiation therapy

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or chemotherapy, after the bone scan which we've marked for identification as Defendant's Exhibit 3 was taken?

A. Not that I'm aware of.

Q. Let's take a look at the fourth and last bone scan. We'll mark that for identification as Exhibit 4.

(Defendant's Exhibit 4 was marked for identification.)

Dr. Chiles, can you identify the date on which this study was performed?

A. 9/30/97.

Q. And can you tell us what you see on the bone scan which we've marked for identification as Defendant's Exhibit 4?

A. Now we see a rather broad focus, a very slightly increased activity within the right posterior hemithorax, and that's encompassing perhaps three or four rib levels. So the previous areas that we've seen, both the initial area in the eighth and ninth rib and in the area of the seventh rib, I don't see any longer.

So I would interpret this as increased activity possibly related to the plural process that's going on within the chest. It does not appear

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confined to the rib anymore, probably the plural process, and this may be the sequela of the radiation therapy to that side.

Q. Do I understand your testimony that both the increased activity that you saw on DX 2 in the eighth and ninth ribs and the increased area of activity that you saw around the sixth rib in DX 3 are not apparent on DX 4?

A. Yes. I think I said seventh rib. But, yeah, I don't see any of those three lesions.

Q. Could any therapy that Mr. Acton received have accounted for the disappearance of the area of increased activity in the sixth or seventh rib area?

A. No. I think if those had been metastatic diseases those would have persisted at this time.

Q. Do you have an opinion as to whether or not the areas of increased activity that appeared in the ribs at different spots on Defendant's Exhibit 2 and Defendant's Exhibit 3 represented metastatic disease?

A. I think they did not represent metastatic disease.

Q. And what is the basis for that opinion?

A. The resolution. With the first -- with the lesions in the eighth and ninth rib, that the appearance of them in two continuous ribs really led

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me to believe that they were traumatic in origin. But then the fact that they resolved and then we have another one showing up, it really suggests to me that there was trauma to the thorax and their resolution this time period suggested to me that they were not metastatic.

Q. What about the area of increased activity in the seventh rib?

A. That resolved. And I think, you know, without any therapy at all, if that had been a metastatic, that would have progressed rather than resolved.

Q. I want to also show you a CT scan which has previously been marked for identification by Mr. Esdale as Plaintiff's Exhibit 9-B. And I want to direct your attention in particular to this particular slice or cut. Can you tell us what cut that is?

A. That's image number 11, but it's been annotated by a person at the CT scanner, presumably the technologist.

Q. Can you, using your grease pencil, identify the area that you described as annotation?

A. Annotation I'm referring to these (indicating) two lines that they've drawn on here,

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A-B and C-D. There's two different lines here (indicating).

Q. And let the record reflect that Dr. Chiles has put a circle around that area; is that correct, Doctor?

A. Yes.

Q. Does that area of annotation there represent mass?

A. No.

Q. What is it?

A. That's the right interlobar or descending coronary artery.

Q. That's a blood vessel?

A. Yes.

Q. Just a couple more questions for clarification. You said in response to Mr. Esdale's question that the rate of growth of the tumor in Mr. Acton's right, lower lung is consistent with carcinoid; is that correct?

A. Yes.

Q. Is the rate of growth of this tumor consistent with small-cell carcinoma?

A. No. I would expect a small cell to be a doubling time of about 30 days. So it's just growing too slowly for a small cell.

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Q. Do you have an opinion as to what Mr. Acton's odds of survival would have been if he had a small-cell carcinoma that was detectable radiologically in February of 1994 but which was not treated at all until April of 1995?

A. He would have expired by now.

Q. One final area. Mr. Esdale had asked you questions about whether you were able to see on the CT taken on April 10th of 1995 what the bronchoscopist, Dr. Perrett, had observed during the procedure that he did. The question I have is do you know whether that CT was taken before or after the bronchoscopy?

A. I think it was taken after the bronchoscopy.

Q. And if it was taken after the bronchoscopy then would it be fair to say that necessarily you could not have seen what the bronchoscopist had seen?

A. I couldn't see anything he had removed, that's for sure.

MR. STUHAN: That's all I have.

Randy.

MR. BASSETT: No questions.

EXAMINATION

BY MR. ESDALE:

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Q. Couple of follow-ups. Are you aware of what dates Mr. Acton received treatments and what type of treatments he received?

A. I know that he received chemotherapy and radiation therapy. I know that it was subsequent to the April '95 CT. I've had access to the medical records so I've had access to those dates but I don't remember them right now off the top of my head.

Q. Aside from the April CT would a polypoid lesion, as prescribed by the bronchoscopist, show up on any regular PA or lateral chest x-rays?

A. That tiny lesion, intrabronchial lesion that he described, would not be visible on a chest x-ray.

Q. And just so we're clear on this, I think you stated earlier it was your opinion that what the bronchoscopist saw or biopsied was a small portion of the mass that you described, the six-centimeter mass?

A. I think more likely than not he was at the edge of the mass.

Q. Do you think -- or do you have any opinions as to whether or not there were two separate carcinoid tumors?

A. I only see evidence for one.

MR. ESDALE: That's all I've got.

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MR. STUHAN: We do not waive review and signing. We do want to sign the transcript. Why don't you send the original to me.

(Whereupon, at 3:29 p.m., the deposition was concluded. Signature was reserved.)

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STATE OF_____)

)

COUNTY OF_____)

I, the undersigned, declare under penalty of perjury that I have read the foregoing transcript, and I have made any corrections, additions, or deletions that I was desirous of making; that the foregoing is a true and correct transcript of my testimony contained therein.

EXECUTED this____ day of _____, 19__, at _____, _____.

(City) (State)

_____

(Witness)

Subscribed and sworn to before me this_____ day of_____, 199 .

Notary Public in and for said County and State

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STATE OF NORTH CAROLINA

COUNTY OF DAVIDSON

CERTIFICATE

I, Beth A. Broom, a Notary Public in and for the State of North Carolina, do hereby certify that there came before me on Wednesday, March 17, 1999, the person hereinbefore named, who was by me duly sworn to testify to the truth and nothing but the truth of his knowledge concerning the matters in controversy in this cause; that the witness was thereupon examined under oath, the examination reduced to typewriting under my direction, and the deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any attorney or counsel employed by the parties hereto or financially interested in the action.

IN WITNESS WHEREOF, I have hereto set my hand and affixed my official notarial seal, this the 22nd day of March, 1999.

Beth A. Broom

Beth A. Broom, Notary Public
My Commission Expires 1/38/2003

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IN THE CIRCUIT COURT FOR
SUMTER COUNTY, ALABAMA

JIMMY C. ACTON, Plaintiff, vs. R. J. REYNOLDS TOBACCO COMPANY; et al., Defendants.	)	CIVIL ACTION NUMBER: CV-96-98

PLAINTIFF'S EXHIBIT

NOTICE OF TAKING DEPOSITION

Please take notice that, pursuant to the Alabama Rules of Civil Procedure, Plaintiff will take the telephonic deposition of Caroline Chiles, M.D., as an expert witness to be called at the trial of this case, upon oral examination before an officer authorized by law to administer oaths.

DEPONENT: Caroline Chiles, M.D.

DATE: March 17, 1999

TIME: 1:00 p.m. / EST

PLACE: Wake Forest University School of Medicine
Department of Radiology
Medical Center Building / Meads Hall
Winston-Salem, North Carolina

The matters on which examination is required and the documents to be produced at the deposition are:

1. Testimony and documents evidencing or relating to any and all documents, correspondence, reports, medical reports, photographs, standards, charts, memos or writings of any kind reviewed by said expert in preparing for this case.

2. Testimony and documents evidencing or relating to any and all documents, correspondence, reports, charts, memos, photographs, measurements, drawings, blueprints, video tapes, or writings of any kind that said expert has relied on in forming opinions and conclusions in this case.

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3. Testimony and documents relating to any and all opinions of said expert in this case, including any reports, memoranda, documents, notes and/or writings of any kind whatsoever reflecting this expert's opinions in this case.

4. Testimony and documents evidencing or relating to the said expert's education, background, experience, qualifications and services, including, but not limited to, a copy of this expert's resume.

5. Testimony and documents evidencing or relating to any and all lawsuits or claims in which said expert has been consulted and/or testified. This should include, but not be limited to, the name of the plaintiff, the name of the defendant, the court where the action was brought and the civil action number.

6. Each and every item of correspondence, memo or other document in this expert's file.

7. Each and every memo, item of correspondence, document or any other item sent from any of the attorneys for the defendant to this expert.

8. A complete list of each and every lawsuit or case this expert has done any consulting work in. This should include, but not be limited to, the attorney whom this expert was working for, civil action number, state and county in which the suit was filed and a brief summary about the facts of the case.

9. Testimony and documents evidencing or relating to all contracts or writings confirming deponents employment in this case.

10. Testimony and documents evidencing or relating to all reports, writings, memoranda, handwritten notes in any form, and any other notes deponent has made, whether handwritten or recorded by audio/visual means, related to this case.

11. Testimony and documents evidencing or relating to all hour sheets or bills.

12. Testimony and documents evidencing or relating to all depositions or summaries of depositions provided to deponent for review in this case.

13. Testimony and documents evidencing or relating to all articles written by deponent on any issue involved in deponent's testimony.

14. All prior depositions given by this deponent on similar issues.

R. GRAHAM ESDALE, JR. (ESD002)
Attorney for Plaintiff

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105 Washington St.
Livingston, AL 35470
(205) 652-9627

J.L. Chestnut, Jr.
Chestnut, Chestnut, Sanders & Pettaway
1405 Jeff Davis Avenue
Selma, AL 36702-1305

FILED BY TIMOTHY

CERTIFICATE OF SERVICE

I hereby certify that I have served a copy of the foregoing document upon all counsel of record as listed below by facsimile transmission and by placing a copy of same in the United States Mail, first class, postage prepaid on this the 8th day of March, 1999.

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IN THE CIRCUIT COURT FOR SUMTER COUNTY, ALABAMA

JIMMY C. ACTON,	)	
	)	
Plaintiff,	)	
	)	CIVIL ACTION NO.
vs.	)	
	)	CV-96-98
R.J. REYNOLDS TOBACCO COMPANY, et al.,	)	
	)	
	)	
Defendants.	)	

DEFENDANTS' EXPERT WITNESS DISCLOSURE OF CAROLINE CHILES, M.D.

Dr. Caroline Chiles is a medical doctor, Board certified radiologist and research scientist who is Professor of Radiology and Section Chief of Thoracic Imaging at Wake Forest University School of Medicine, Wake Forest University School of Medicine, Winston-Salem, North Carolina. She received her medical degree from Duke University School of Medicine in 1979, completed her residency in Diagnostic Radiology at Stanford University Medical Center in 1984, and completed her fellowship in Thoracic Imaging at Duke University Medical Center in 1985. She is licensed to practice medicine in North Carolina. A copy of Dr. Caroline Chiles' curriculum vitae is attached hereto.

Dr. Chiles will be offered as an expert in the field of radiology as it relates to the role of a radiologist in the diagnosis of disease; the diagnosis of Mr. Acton's tumor; and the factors associated with the diagnosis of Mr. Acton's tumor. Dr. Chiles may also be called upon to comment on matters raised in the testimony of other witnesses as they relate to her area of expertise.

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Dr. Chiles will testify regarding the techniques, procedures and criteria used by radiologists to diagnose diseases, including cancer.

It is Dr. Chiles' opinion that Mr. Acton had a single, lobulated, rounded lung mass in the right lower lobe, more likely than not present since June of 1994. Furthermore, it is Dr. Chiles' opinion that based on currently available films and medical records, there is no radiological evidence of metastatic disease. Based on the available radiology, the medical history, and the clinical course, it is Dr. Chiles' opinion that this mass more likely represents a carcinoid than a small cell lung carcinoma. Carcinoid growths, such as Dr. Chiles believes Mr. Acton had, have not been statistically associated with exposure to cigarette smoke.

Dr. Chiles bases her opinions on her education, training and experience, research and publications, her review of the pertinent scientific and medical literature reasonably relied upon by other members of her profession, Mr. Acton's medical records, radiology, witness statements in this proceeding, and other information about Mr. Acton.

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CURRICULUM VITAE

NAME: Caroline Chiles, M.D.

SOCIAL SECURITY NUMBER: [DELETED]

ADDRESS:

Residence: [DELETED]

Business: Department of Radiology
Wake Forest University School of Medicine
Medical Center Boulevard
Winston-Salem, North Carolina 27157-1088
Telephone: (336) 716-4316

PERSONAL INFORMATION:

Birthplace and Date: Rochester, Minnesota
[DELETED] 1953

Citizenship: USA

Marital Status: Married

Spouse: Willis Slane

EDUCATION:

College:	Massachusetts Institute of Technology Cambridge, Massachusetts S.B. in Mechanical Engineering	1972-1976
Honors and Awards:	Tau Beta Pi	1975
Medical School:	Duke University School of Medicine Durham, North Carolina M.D.	1976-1979

POSTDOCTORAL TRAINING:

Internship and Residency:	Division of Diagnostic Radiology Stanford University Medical Center Stanford, California	1980-1984

February 1998

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POSTDOCTORAL TRAINING (continued):

Fellowship:	Thoracic Imaging Department of Radiology Duke University Medical Center Durham, North Carolina	1984-1985

PROFESSIONAL LICENSURE:

North Carolina #28152 (active)
Virginia #0101046120
California #G047358
Michigan #4301056486
South Carolina #15289
Tennessee #021312
Kentucky #27825

SPECIALTY CERTIFICATION:	American Board of Radiology	1984
	"B" Reader Department of Health and Human Services Public Health Service, Centers for Disease Control and Prevention National Institute for Occupational Safety and Health Appalachian Laboratory for Occupational Safety and Health	12/1996 -

EMPLOYMENT:

Academic Experience:	Assistant Professor of Radiology Duke University Medical Center Durham, North Carolina	7/85-6/90
	Associate Professor of Radiology Medical College of Virginia Richmond, Virginia	1/91-12/93
	Associate Professor of Radiology Bowman Gray School of Medicine Winston-Salem, North Carolina	1/94-6/97
	Professor of Radiology Bowman Gray School of Medicine Winston-Salem, North Carolina	7/97-

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EMPLOYMENT (continued):

Academic Experience (continued):

Section Chief of Thoracic Imaging Bowman Gray School of Medicine Winston-Salem, North Carolina	7/96-

Teaching Experience:

Coordinator - Radiology Instruction for Physician's Assistant Students Duke University Medical Center	1986-1990
Coordinator - Radiology Rotation for Family Medicine Residents Duke University Medical Center	1988-1990
Lecturer - Unit V Radiology for 3rd year medical students Bowman Gray School of Medicine	1994-1996
Lecturer - Units I-II Radiologic Anatomy for 1st year medical students Bowman Gray School of Medicine	1996-
Lecturer - Units III-IV Radiology for 2nd year medical students Bowman Gray School of Medicine	1996-
Coordinator - Unit VI Radiology Elective for 4th year medical students Bowman Gray School of Medicine	1996-
Coordinator - Wilhelm Roentgen Society (radiology interest group for Bowman Gray School of Medicine students)	1996-
Sponsor: NIH Medical Student Research Training Program Summer Research Project Kuo WT: Evaluation of Contrast CT of Lymphoma of the Pleura Bowman Gray School of Medicine	6/97-8/97

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EMPLOYMENT (continued):

Special Committee Work:

Departmental:	Resident Selection Committee Duke University Medical Center	1985-1990
	Radiology Quality Assurance Committee Duke University Medical Center	1987-1990
	Radiology Resident Selection Committee Bowman Gray School of Medicine	1995-
Hospital:	Emergency Department Advisory Committee Duke University Medical Center	1986-1988
	MRI Committee McGuire VA Medical Center Richmond, Virginia	1991-1993
	Academic Committee McGuire VA Medical Center Richmond, Virginia	1991-1993
	Task Force for Imaging Film Supplier SunHealth Alliance	1995-1996
Medical School:	Clinical Research Practices Committee Bowman Gray School of Medicine	1996-
	Curriculum for 2002 Committee Bowman Gray School of Medicine	1996-1997
	Lung Cancer Affinity Group Bowman Gray School of Medicine	1996-
	Student Discipline Committee Bowman Gray School of Medicine	1997-2000

Professional Experience:	Founding Partner Teleradiology Associates Durham, North Carolina	7/90-6/91

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OTHER PROFESSIONAL APPOINTMENTS AND ACTIVITIES:

Editorial:	Editorial Board Investigative Radiology	1989-1990
	Coeditor "Chest Film Clinic" Journal of Respiratory Diseases	1989-
	Reviewer Chest	1990-
	Guest Editor Lung Imaging Seminars in Respiratory	July 1992
	Reviewer Journal of Computer Assisted Tomography	1995-
	Reviewer American Journal of Roentgenology	1996-
	Coeditor Pulmonary and Cardiac Imaging, textbook in Lung Biology in Health and Disease Series	1997 publication

VISITING PROFESSORSHIPS:

1. Department of Radiology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, March 23, 1990.
2. Department of Radiology, Vanderbilt University, Nashville, Tennessee, May 21-22, 1990.
3. Department of Radiology, Eastern Virginia Medical School, Norfolk, Virginia, March 6-7, 1991.
4. Department of Radiology, University of California at Los Angeles, Los Angeles, California, November 12, 1992.
5. Department of Radiology, Louisiana State University Medical Center, New Orleans, Louisiana, April 5-8, 1993.

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VISITING PROFESSORSHIPS (continued):

6. Department of Radiology, Medical University of South Carolina, Charleston, South Carolina, April 21, 1997.

7. Department of Radiology, Foothills Hospital, University of Calgary, Calgary, Alberta, Canada, February 19-20, 1998.

GRANTS:

North Carolina Baptist Hospital Developmental Technology Fund
July 1, 1994
$15,830
Magnetic Resonance Imaging of Chest Wall Invasion in Non-Small Cell Lung Cancer
Investigators: Caroline Chiles, M.D., Robert H. Choplin, M.D., Kerry M. Link, M.D., J. Jeffrey Carr, M.D.

PROFESSIONAL MEMBERSHIPS:

Society of Thoracic Radiology	1986
Association of University Radiologists	1987-1990
American Roentgen Ray Society	1987
Sigma Xi	1987
American College of Chest Physicians	1988-1990
Radiological Society of North America	1988
Program Subcommittee November 1996 Meeting	1995, 1996
Southern Medical Association	1992

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HONORS AND AWARDS:

Radiological Society of North America Scholar Award $90,000 grant support	1987-1989
Certificate of Merit for Scientific Exhibit Radiological Society of North America (See citation #34 under Lectures, Speeches, Scientific Exhibits)	1988
Duke Radiology Resident Teaching Award Duke University Medical Center Durham, North Carolina	1990
Examiner, Chest Radiology Oral Board Examinations American Board of Radiology Louisville, Kentucky	1995, 1996
Magna Cum Laude Award for Scientific Exhibit Radiological Society of North America (See citation #77 under Lectures, Speeches, Scientfic Exhibits)	1997

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LECTURES, SPEECHES, SCIENTIFIC EXHIBITS:

1. Chiles C, Ravin CE. Physical properties governing the interrelationship of pressure, flow and volume in collapsible tubes. Presented at the Association of University Radiologists meeting, New Orleans, Louisiana, April 1981.

2. Chiles C, Guthaner D, Djang WT. Detection of pulmonary emboli in dogs using digital subtraction angiography. Presented at the Association of University Radiologists meeting, Mobile, Alabama, April 1983.

3. Chiles C, Guthaner DF, Jamieson SW, Stinson EB, Oyer PE, Silverman FJ. Heart-lung transplantation: the postoperative chest radiograph. Presented at the Association of University Radiologists meeting, Newport Beach, California, May 1984.

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5. Chiles C, Hedlund LW, Kubek JR, Harris CC, Sullivan DC, Tsai JC, Putman CE. Peripheral distribution of large diameter microspheres in the dog lung in the axial plane. Presented at the Association of University Radiologists meeting, Nashville, Tennessee, May 1985.

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7. Chiles C. New imaging modalities. Presented at the Third Annual Winter Symposium: Selected Topics in Internal Medicine. Snowshoe, West Virginia, February 3-5, 1986.

8. Chiles C. Pulmonary masses. Presented at the First Annual Duke Radiology Review Course, Durham, North Carolina, April 28, 1986.

9. Chiles C. Introduction to cardiac radiology. Presented at the First Annual Duke Radiology Review Course, Durham, North Carolina, April 28, 1986.

10. Chiles C. Acquired heart disease. Presented at the First Annual Duke Radiology Review Course, Durham, North Carolina, April 28, 1986.

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13. Chiles C, Newman GE, Blinder RA. SPECT imaging of the bronchial circulation in sheep. Presented at the Association of University Radiologists meeting, Charleston, South Carolina, March 1987.

14. Chiles C, MacGregor JH, Silverman PM. CT appearance of the chest wall following treatment of breast cancer. Exhibited at the American Roentgen Ray Society meeting, Miami Beach, Florida, April 1987.

15. Chiles C. Pulmonary masses. Presented at the Second Annual Duke Radiology Review Course, Durham, North Carolina, April 20, 1987.

16. Chiles C. Introduction to cardiac radiology. Presented at the Second Annual Duke Radiology Review Course, Durham, North Carolina, April 20, 1987.

17. Chiles C. Acquired heart disease. Presented at the Second Annual Duke Radiology Review Course, Durham, North Carolina, April 20, 1987.

18. Chiles C. Radiographic manifestations of rupture of the thoracic aorta. Presented at the Tenth Annual Duke Radiology Postgraduate Course, Pine Knoll Shores, North Carolina, July 27, 1987.

19. Chiles C. The thoracic aorta. Presented at the Duke University Medical Center, Department of Radiology, Fourteenth Annual Symposium of Diagnostic Imaging, Bermuda, October 12, 1987.

20. Chiles C. The chest wall - plain film and CT observations. Presented at he Duke University Medical Center, Department of Radiology, Fourteenth Annual Symposium of Diagnostic Imaging, Bermuda, October 14, 1987.

21. Chiles C. Intrathoracic metastasis from an extrathoracic primary. Presented at the Duke University Medical Center, Department of Radiology, Fourteenth Annual Symposium of Diagnostic Imaging, Bermuda, October 16, 1987.

22. Chiles C. The thoracic aorta; the chest wall-plain film and CT observations; and intrathoracic metastasis from an extrathoracic primary. Presented at the Department of Radiology, Wilford Hall Air Force Base, San Antonio, Texas, November 20, 1987.

23. Chiles C. Chest CT-when is it useful? Presented at the Selected Topics Symposium, Durham, North Carolina, February 15, 1988.

24. Chiles C. A review of chest radiology-pattern recognition. Presented at the First Annual Physician's Assistant Certification Review Course, Durham, North Carolina, March 4, 1988.

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28. Chiles C. Introduction to cardiac radiology. Presented at the Third Annual Duke Radiology Review Course, Durham, North Carolina, April 25, 1988.

29. Chiles C. Acquired heart disease. Presented at the Third Annual Duke Radiology Review Course, Durham, North Carolina, April 25, 1988.

30. Chiles C. Lesions of the chest wall. Presented at the Eleventh Annual Duke Radiology Postgraduate Course, Pine Knoll Shores, North Carolina, July 28, 1988.

31. Chiles C. Aortic rupture. Presented at the Refresher Course, North Carolina Chapter of the American College of Radiology, Greensboro, North Carolina, November 5, 1988.

32. Vail CM, Chiles C, Coblentz CL, Carroll BA. Radiographic evaluation of intraaortic balloon pumps. Presented by Dr. Vail at the Radiological Society of North America meeting, Chicago, Illinois, November 1988.

33. Bergin CJ, Bell DY, Coblentz CL, Chiles C, Putman CE, MacIntyre N, Coleman E, Wilkinson WE. CT of sarcoidosis: variation and significance of parenchymal disease. Presented by Dr. Bergin at the Radiological Society of North America meeting, Chicago, Illinois, November 1988.

34. Bergin C, Coblentz C, Roggli V, Chiles C, Ravin CE. The secondary lobule: diseases affecting lymphatic channels. Exhibited at the American Roentgen Ray Society meeting, San Francisco, California, May 1988, and at the Radiological Society of North America meeting, Chicago, Illinois, November 1988. Certificate of Merit citation, RSNA, November 1988.

35. Chiles C. A review of chest radiology-pattern recognition. Presented at the Second Annual Physician's Assistant Certification Review Course, Durham, North Carolina, March 3, 1989.

36. Chiles C. Pulmonary masses. Presented at the Fourth Annual Duke Radiology Review Course, Durham, North Carolina, April 1989.

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LECTURES, SPEECHES, SCIENTIFIC EXHIBITS (continued):

37. Chiles C. Introduction to cardiac radiology. Presented at the Fourth Annual Duke Radiology Review Course, Durham, North Carolina, April 1989.

38. Chiles C. Acquired heart disease. Presented at the Fourth Annual Duke Radiology Review Course, Durham, North Carolina, April 1989.

39. Bergin CJ, Coblentz CL, Chiles C, Bell DY, Castellino RA. CT identification of chronic lung diseases. Presented by Dr. Bergin at the American Roentgen Ray Society meeting, New Orleans, Louisiana, May 1989.

40. Bass J, Chiles C. Analysis of correlation between skills in visual perception and radiologic diagnostic performance. Presented by Dr. Bass at the Association of University Radiologists meeting, Seattle, Washington, May 1989.

41. Chiles C. High resolution CT in the diagnosis of pulmonary disease. Presented at the Ninth Annual Duke Radiology Postgraduate Course, Pine Knoll Shores, North Carolina, July 27, 1989.

42. Chiles C, Muller NL, Kullnig P. Pulmonary lymphangioleiomyomatosis: CT appearance and correlation with pulmonary function. Presented at the Society of Thoracic Radiology meeting, Naples, Florida, January 1990.

43. Chiles C. A review of chest radiology-pattern recognition. Presented at the Third Annual Physician's Assistant Certification Review Course, Durham, North Carolina, March 1990.

44. Chiles C. Pulmonary masses. Presented at the Fifth Annual Duke Radiology Review Course, Durham, North Carolina, April 1990.

45. Chiles C. Introduction to cardiac radiology. Presented at the Fifth Annual Duke Radiology Review Course, Durham, North Carolina, April 1990.

46. Chiles C. Acquired heart disease. Presented at the Fifth Annual Duke Radiology Review Course, Durham, North Carolina, April 1990.

47. Chiles C. CT of the chest. Presented at the Refresher Course, North Carolina Chapter of the American College of Radiology, Durham, North Carolina, May 18, 1990.

48. Chiles C. Interstitial lung disease diagnosis with high-resolution CT. Presented at the Eastern Virginia Radiological Society meeting, Norfolk, Virginia, March 6, 1991.

49. Chiles C. The thoracic aorta-transection and dissection. Presented at the Department of Radiology, Eastern Virginia Medical School, Norfolk, Virginia, March 7, 1991.

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51. Chiles C. New film-screen combinations for chest radiology. Presented at the University of California at Los Angeles, Department of Radiology, Los Angeles, California, November 12, 1992.

52. Chiles C, Blinder RA, Bampton AEH. Surface coil MR imaging of the chest wall in patients with peripheral bronchogenic carcinoma. Exhibited at the Radiological Society of North America meeting, Chicago, Illinois, November 1992. Abstract: Radiology 1992; 185(P):355.

53. Chiles C, Blinder RA, Bampton AEH. Chest wall invasion by bronchogenic carcinoma-spectral fat-suppressed gadolinium-enhanced MR imaging. Presented at the Society of Thoracic Radiology meeting, Hilton Head, South Carolina, March 1993.

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55. Tarry CT, Chiles C, Cole TJ. Fluid accumulation within a preexisting bulla. Exhibited at the Radiological Society of North America meeting, Chicago, Illinois, November 1993. Abstract: Radiology 1993; 189(P):433.

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57. Chiles C. Aortic trauma. Presented at the Winter Radiology Continuing Education Program, sponsored by the Bowman Gray School of Medicine, Curaçao, Netherlands Antilles, January 21-28, 1995.

58. Chiles C. Staging of lung cancer. Presented at the Winter Radiology Continuing Education Program, sponsored by the Bowman Gray School of Medicine, Curaçao, Netherlands Antilles, January 21-28, 1995.

59. Chiles C. Chest MR - selection of scan parameters. Presented at the Winter Radiology Continuing Education Program, sponsored by the Bowman Gray School of Medicine, Curaçao, Netherlands Antilles, January 21-28, 1995.

60. Chiles C. High resolution CT of pulmonary parenchymal disease. Presented at the North Carolina Thoracic Society meeting, New Bern, North Carolina, April 8, 1995.

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62. Ely EW, Johnson MM, Chiles C, Bowton DL, Rushing JR, Freimanis RI, Choplin RH, Haponik EF. Objective chest x-ray (CXR) measurements correlate with mechanical ventilator parameters in ICU patients. Exhibited at the American Thoracic Society meeting, Seattle, Washington, May 21-24, 1995. Abstract: Am J Respir Crit Care Med 1995; 151:A334.

63. Chen MY, Chiles C, Choplin RH. Survey of CT protocols for staging of brochogenic carcinoma. Exhibited at the Annual Meeting of the American Roentgen Ray Society, Washington, DC, May 1, 1995, and at the Eighty-first Scientific Assembly and Annual Meeting of Radiological Society of North America meeting, Chicago, Illinois, November 1995. Abstract: Am J Roentgenol 1995; 164:(3Suppl):27-28, and Radiology 1995; 197(P):528.

64. Creasy JD, Chiles C, Routh WD, Dyer RB. Traumatic thoracic aortic injury: pictorial review. Exhibited at the Radiological Society of North America meeting, Chicago, Illinois, November 1995. Abstract: Radiology 1995; 197(P):528.

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66. Chiles C. High resolution CT of pulmonary parenchymal disease. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine, Aruba, January 22-26, 1996.

67. Chiles C. Extrathoracic staging of lung cancer. Presented at the Society of Thoracic Radiology meeting, Mauna Lani, Hawaii, February 18, 1996.

68. Chiles C. When to order a CXR, and how to understand the report. Presented at Common Clinical and Practice Skills Symposium, Southern Medical Association, Atlanta, Georgia, April 26, 1996.

69. Ely EW, Johnson MM, Chiles C, Rushing JT, Bowton DL, Freimanis RI, Choplin RH, Haponik EF. An objective protocol in ventilated patients shortens weaning time. A poster presentation at the American Thoracic Society International Conference, New Orleans, Louisiana, May 11-15, 1996.

70. Thomason JWW, Ely EW, Chiles C, Ferretti G, Haponik EF. Radiologic evaluation of pulmonary edema in mechanically ventilated ICU patients using supine portable chest x-rays (CXR). Presented by Mr. Thomason (MS) at the American Thoracic Society International Conference, New Orleans, Louisiana, May 11-15, 1996.

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LECTURES, SPEECHES, SCIENTIFIC EXHIBITS (continued):

71. Chiles C. Pleural drainage catheter placement. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine, Aruba, January 19-25, 1997.

72. Chiles C. Extrathoracic staging of lung cancer. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine, Aruba, January 19-25, 1997.

73. Chiles C. High-resolution CT of pulmonary parenchymal disease. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine, Aruba, January 19-25, 1997.

74. Ferretti G, Lörcher U, Chiles C, Thony F, Coulomb M. Chest imaging in HIV-positive patients (Part I). Presented by Dr. Ferretti at the AIDS European Congress of Radiology, Vienna, Austria, March 2-7, 1997.

75. Chiles C. High-resolution CT of pulmonary parenchymal disease. Presented at the Low Country Radiology Society, Charleston, South Carolina, April 21, 1997.

76. Chiles C. A radiographic approach to diffuse lung disease. Presented at the Department of Radiology, Medical University of South Carolina, Charleston, South Carolina, April 21, 1997.

77. Davis KW, Chiles C, Williams DW III. Navigating the thoracic inlet. Exhibited at the Eighty-third Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 30 - December 5, 1997. Magna Cum Laude Award 1997.

78. Chiles C. Staging lung cancer. Presented at the Foothills Hospital, Department of Radiology, University of Calgary, Calgary, Alberta, Canada, February 19-20, 1998.

79. Chiles C. High resolution CT of lung disease. Presented at the Foothills Hospital, Department of Radiology, University of Calgary, Calgary, Alberta, Canada, February 19-20, 1998.

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4. Chiles C, Putman CE. New imaging techniques. In: Cherniack R, ed, Current therapy of respiratory disease. Toronto: BC Decker, 1989:6-15.

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9. Chiles C. Acquired heart disease. In: Ravin C, Cooper C, eds, Duke radiology review. Philadelphia: WB Saunders, 1990:28-32.

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11. Chiles C. Radiologic recognition of complications of thoracic surgery. In: Wolfe WG, ed, Complications in thoracic surgery: recognition and management. St. Louis: Mosby-Year Book, 1992:60-75.

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Wake Forest University School of Medicine
Curriculum Vitae

NAME: Caroline Chiles, M.D.

CURRENT ACADEMIC TITLE: Professor of Radiologic Sciences-Radiology

CURRENT ADMINISTRATIVE TITLE: Section Chief of Thoracic Imaging

ADDRESS:

Residence: [DELETED]

Business: Department of Radiology
Division of Radiologic Sciences
Wake Forest University School of Medicine
Medical Center Boulevard
Winston-Salem, North Carolina 27157-1088
Telephone: (336) 716-4316

PERSONAL INFORMATION:

Birthplace: Rochester, Olmsted County, Minnesota, U.S.A
Date of Birth: [DELETED] 1953

Citizenship: United States of America

Marital Status: Married

Spouse: Willis Slane

EDUCATION:

College:	Massachusetts Institute of Technology Cambridge, Massachusetts Bachelor of Science in Mechanical Engineering	1972-1976
Medical School:	Duke University School of Medicine Durham, North Carolina Doctor of Medicine	1976-1979
Honors and Awards:	Tau Beta Pi	1975

POSTDOCTORAL TRAINING:

Internship and Residency:	Division of Diagnostic Radiology Stanford University Medical Center Stanford, California	1980-1984

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POSTDOCTORAL TRAINING (continued):

Fellowship:	Thoracic Imaging Department of Radiology Duke University Medical Center Durham, North Carolina	1984-1985

PROFESSIONAL LICENSURE:

North Carolina #28152 (active)	1984
Virginia #0101046120	
California #G047358	
Michigan #4301056486	
South Carolina #15289	
Tennessee #021312	
Kentucky #27825	

SPECIALTY CERTIFICATION:

American Board of Radiology	1984
"B" Reader Department of Health and Human Services Public Health Service, Centers for Disease Control and Prevention National Institute for Occupational Safety and Health Appalachian Laboratory for Occupational Safety and Health	1996 -

EMPLOYMENT:

Academic Experience:	Professor of Radiology Wake Forest University School of Medicine Winston-Salem, North Carolina	1997-
	Section Chief of Thoracic Imaging Bowman Gray School of Medicine Winston-Salem, North Carolina	1996-
	Associate Professor of Radiology Bowman Gray School of Medicine Winston-Salem, North Carolina	1994-1997
	Associate Professor of Radiology Medical College of Virginia Richmond, Virginia	1991-1993

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EMPLOYMENT (continued):

Academic Experience (continued):

	Assistant Professor of Radiology Duke University Medical Center Durham, North Carolina	1985-1990
Professional Experience:	Founding Partner Teleradiology Associates Durham, North Carolina	1990-1991

OTHER PROFESSIONAL APPOINTMENTS AND INSTITUTIONAL SERVICE:

Editorial Work:	Editorial Board Investigative Radiology	1989-1990
	Coeditor "Chest Film Clinic" Journal of Respiratory Diseases	1989-
	Reviewer Chest	1990-
	Guest Editor Lung Imaging Seminars in Respiratory Medicine	July 1992
	Reviewer Journal of Computer Assisted Tomography	1995-
	Reviewer AJR American Journal of Roentgenology	1996-
	Reviewer Radiology	1997-
	Reviewer Radiological Society of North America Research and Education Fund	1998-

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OTHER PROFESSIONAL APPOINTMENTS AND INSTITUTIONAL SERVICE (continued):

Hospital, School, Medical Center Committees:

Radiology Resident Selection Committee Duke University Medical Center	1985-1990
Emergency Department Advisory Committee Duke University Medical Center	1986-1988
Radiology Quality Assurance Committee Duke University Medical Center	1987-1990
MRI Committee McGuire VA Medical Center Richmond, Virginia	1991-1993
Academic Committee McGuire VA Medical Center Richmond, Virginia	1991-1993
Radiology Resident Selection Committee Bowman Gray School of Medicine	1995-1997
Task Force for Imaging Film Supplier SunHealth Alliance Bowman Gray School of Medicine	1995-1996
Clinical Research Practices Committee Bowman Gray School of Medicine	1996-1998
Curriculum for 2002 Committee Bowman Gray School of Medicine	1996-1997
Lung Cancer Affinity Group Bowman Gray School of Medicine	1996-
Student Discipline Committee Bowman Gray School of Medicine	1997-2000
Member, Search Committee for Chairman of Department of Otolaryngology Wake Forest University School of Medicine	1997-1998

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OTHER PROFESSIONAL APPOINTMENTS AND INSTITUTIONAL SERVICE (continued):

Committee, Council, and Board Appointments (National):

National Cancer Institute Screening and Early Detection Task Force Imaging Sciences Working Group	1998-

PROFESSIONAL MEMBERSHIPS:

Society of Thoracic Radiology	1986-
Workshop on Radiographic Definitions of Lung Injury Seattle, Washington	1998
Co-chairman, Scientific Program Committee	1998-1999
Association of University Radiologists	1987-1990
American Roentgen Ray Society	1987-
Program Subcommittee	1998-1999
Sigma Xi	1987
American College of Chest Physicians	1988-1990
Radiological Society of North America	1988-
Program Subcommittee	1995-1999
Research and Education Foundation Roster of Distinguished Scientific Advisors	1999-
Southern Medical Association	1992-

HONORS AND AWARDS:

Awards:	Radiological Society of North America Scholar Award $90,000 grant support	1987-1989
	Certificate of Merit The secondary lobule: diseases affecting lymphatic channels [Scientific Exhibit] 74th Scientific Assembly and Annual Meeting of the Radiological Society of North America	1988

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HONORS AND AWARDS (continued):

Awards (continued):	Magna Cum Laude Award Navigating the thoracic inlet [Scientific Exhibit] 83rd Scientific Assembly and Annual Meeting of the Radiological Society of North America	1997
Honors:	Invited Examiner, Chest Radiology Oral Board Examinations American Board of Radiology Louisville, Kentucky	1995, 1996, 1998

GRANT HISTORY:

North Carolina Baptist Hospital Developmental Technology Fund
July 1, 1994-1996
$15,830
Magnetic Resonance Imaging of Chest Wall Invasion in Non-Small Cell Lung Cancer
Investigators: Caroline Chiles, M.D., Robert H. Choplin, M.D., Kerry M. Link, M.D., J. Jeffrey Carr, M.D.

BIBLIOGRAPHY:

Books:

1. Chiles C, Putman CE, eds. Pulmonary and Cardiac Imaging. New York: Marcel Dekker, 1997.

Chapters in Books:

1. Goodwin DA, McDougall IR, Chiles C, Paldi J, Krieves D, Gainey M. Diagnostic usefulness of imaging with labelled white blood cells. In: II symposium on cell labelling. Central Chapter of the Society of Nuclear Medicine, November 1982.

2. Chiles C. Alveolar disease in the adult. In: Putman CE, Ravin CE, eds. Textbook of diagnostic imaging. Philadelphia: WB Saunders,1988:521-527.

3. Chiles C, Hedlund LW, Putman CE. Diagnostic imaging of inhalation lung injury. In: Loke J, ed. Pathophysiology and treatment of inhalation injuries. New York: Marcel Dekker, 1988:187-206.

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Chapters in Books (continued):

3. Chiles C, Hedlund LW, Putman CE. Diagnostic imaging of inhalation lung injury. In: Loke J, ed. Pathophysiology and treatment of inhalation injuries. New York: Marcel Dekker, 1988:187-206.

4. Chiles C, Putman CE. New imaging techniques. In: Cherniack RM, ed. Current therapy of respiratory disease. Toronto: BC Decker, 1989:6-15.

5. Coblentz CL, Chiles C, Putman CE. Radiologic evaluation. In: Haponik EF, Munster AM, eds. Respiratory injury: smoke inhalation and burns. New York: McGraw-Hill, 1990:179-194.

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7. Chiles C. Pulmonary masses. In: Ravin C, Cooper C, eds. Duke radiology review. Philadelphia: WB Saunders, 1990:9-16.

8. Chiles C. Introduction to cardiac radiology. In: Ravin C, Cooper C, eds. Duke radiology review. Philadelphia: WB Saunders, 1990:21-28.

9. Chiles C. Acquired heart disease. In: Ravin C, Cooper C, eds. Duke radiology review. Philadelphia: WB Saunders, 1990:28-32.

10. Chiles C, Putman CE. Acute thoracic trauma. In: Goodman LR, Putman CE, eds. Critical care imaging. 3rd ed. Philadelphia: WB Saunders, 1992:199-212.

11. Chiles C. Radiologic recognition of complications of thoracic surgery. In: Wolfe WG, ed. Complications in thoracic surgery: recognition and management. St. Louis: Mosby-Year Book, 1992:60-75.

12. Chiles C. The chest wall and pleura-normal and abnormal. In: Tarver R, Newell J, eds. Thoracic radiology. New York: Raven Press, 1993:85-110.

13. Chiles C. Alveolar disease in the adult. In: Putman C, Ravin C, eds. Textbook of diagnostic imaging, 2nd ed. Philadelphia: WB Saunders, 1993:489-495.

14. Chiles C, Choplin RH. Radiology of the chest. In: Chen MYM, Pope TL Jr, Ott DJ, eds. Basic radiology. New York: McGraw Hill, 1996:73-144.

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16. Chiles C, Putman CE. Thoracic imaging: 1896-present. In: Chiles C, Putman CE, eds. Pulmonary and cardiac imaging. New York: Marcel Dekker, 1997:3-18.

17. Cox JE, Chiles C. Extrathoracic staging of non-small cell lung cancer. In: Taveras JM, Ferrucci JT, eds. Radiology-Diagnosis-Imaging-Intervention. Philadelphia: Lippincott-Raven Publishers, 1998:1-17.

Journal Articles:

1. Chiles C, Ravin CE. Physical principles governing the interrelationships of pressure, flow and volume in collapsible tubes. Invest Radiol 1981; 16:525-527.

2. Chiles C, Guthaner DF, Djang WT. Detection of pulmonary emboli in dogs using digital subtraction angiography. Invest Radiol 1983; 18:507-511.

3. Chiles C, Guthaner DF, Jamieson SW, Stinson EB, Oyer PE, Silverman JF. Heart-lung transplantation: the postoperative chest radiograph. Radiology 1985; 154:299-304.

4. Chiles C, Adams GW, Ravin CE. Radiographic manifestations of cardiac sarcoid. Am J Roentgenol 1985; 145:711-714.

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10. Chiles C, Hedlund LW, Kubeck RJ, Harris C, Sullivan DC, Tsai JC, Putman CE. Distribution of 15- and 137-mμ diameter microspheres in the dog lung in the axial plane. Invest Radiol 1986; 21:618-621.

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12. Chiles C, Baker ME, Silverman PM. Superior pericardial recess simulating aortic dissection on computed tomography. J Comput Assist Tomogr 1986; 10:421-423.

13. Sussman SK, Chiles C, Cooper C, Lowe JE. CT demonstration of myocardial perforation by a pacemaker lead. J Comput Assist Tomogr 1986; 10:670-672.

14. MacGregor JH, Chiles C, Godwin JD, Ravin CE. Imaging of the axillary subsegment of the right upper lobe. Chest 1986; 90:763-765.

15. Neumann CH, Hussain S, Selzer SE, Chiles C, Castellino RA. Computed tomography of the liver in newly diagnosed Hodgkin disease and non-Hodgkin lymphoma: staging implications. Tumor Diagnostik & Therapie 1986; 7:1-4.

16. Sherrier RH, Chiles C, Johnson GA, Ravin CE. Differentiation of benign from malignant pulmonary nodules with digitized chest radiographs. Radiology 1987; 162:645-649.

17. MacGregor JH, Chan JT, Chiles C, Kier R, Godwin JD, Ravin CE. The radiographic distinction between pericardial and myocardial calcification. Am J Roentgenol 1987; 148:675-677. Abstracted, Year Book of Diagnostic Radiology 1989:239-241.

18. Vail CM, Chiles C. Invasive pulmonary aspergillosis: radiologic evidence of tracheal involvement. Radiology 1987; 165:745-746.

19. Coblentz CL, Sallee DS, Chiles C. Aortobronchopulmonary fistula complicating aortic aneurysm: diagnosis in four cases. Am J Roentgenol 1988; 150:535-538.

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28. Sherrier RH, Chotas HG, Johnson GA, Chiles C, Ravin CE. Image optimization in a computed-radiography/photostimulable-phosphor system. Digit Imaging 1989; 2:212-219.

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32. Chiles C, Putman CE. Radiology in lung cancer. Part I: Cancer staging and conventional radiography. Respiratory Management 1990; 20:69-72.

33. Chiles C, Putman CE. Radiology in lung cancer. Part II: Computed tomography. Respiratory Management 1990; 20:96-98.

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35. Bass JC, Chiles C. Visual skill. Correlation with detection of solitary pulmonary nodules. Invest Radiol 1990; 25:994-998. Abstracted, Year Book of Diagnostic Radiology 1992:77-79.

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Journal Articles (continued:

36. Chiles C, Kussin P. Why the nonresolving pneumonia? Journal of Respiratory Diseases 1990; 11:735-738.

37. Primack S, Chiles C, Putman CE. Thoracic imaging in the intensive care unit. Clinical Intensive Care 1991; 2:26-40.

38. Chiles C, Putman CE. What is the cause of pneumonia in this transplant recipient? Journal of Respiratory Diseases 1991; 12:147-149.

39. Chiles C. A radiographic approach to diffuse lung disease. Radiol Clin North Am 1991; 29:919-929.

40. Chiles C, Swain ME, Effman EL. Why the hyperlucent lung in an adolescent? Journal of Respiratory Diseases 1991; 12:911-914.

41. Rhodes RE, Chiles C, Vick WW. Talc granulomatosis presenting as spontaneous pneumothorax. South Med J 1991; 84:929-930.

42. Chiles C, Vail CM, Coblentz CL, Carroll BA. Intra-aortic balloon pumps: an update on radiographic recognition. Can Assoc Radiol J 1991; 42:257-260.

43. Debatin JF, Chiles C. A 50-year old man with nonresolving pneumonia. Journal of Respiratory Diseases 1992; 13:58-65.

44. Muller NL, Chiles C, Kullnig P. Pulmonary lymphangiomyomatosis: correlation of CT with radiographic and functional findings. Radiology 1990; 175:335-339. Abstracted, Year Book of Diagnostic Radiology 1992:44-45.

45. Chiles C, Listello D. Opacification of the right upper lobe in an elderly man. Journal of Respiratory Diseases 1992; 13:417-422.

46. Primack S, Chiles C, Putman CE. One hundred years of medical imaging: new benefits, new challenges. Perspect Biol Med 1992: 35:361-371.

47. Weir IH, Muller NL, Chiles C, Godwin JD, Lee SH, Kullnig P. Wegener's granulomatosis: findings from computed tomography of the chest in 10 patients. Can Assoc Radiol J 1992; 43:31-34.

48. Chiles C, Putman CE. Pulmonary sarcoidosis. Seminars in Respiratory Medicine 1992; 13:345-357.

49. Chiles C, Putman CE. Radiographic diagnosis of acute pulmonary disease in the ICU. Journal of Critical Illness 1994; 9:198-206.

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BIBLIOGRAPHY (continued):
Journal Articles (continued:

50. Chiles C, Listello D. An apical lesion and chest pain. Journal of Respiratory Diseases 1994; 15:349-354.

51. Dunn MM, Chiles C. A patient with CHF, V-tach and progressive decline. Journal of Respiratory Diseases 1994; 15:1076-1078,1081.

52. Cox JE, Chiles C. An abnormal chest film in an asymptomatic cigarette smoker. Journal of Respiratory Diseases 1995; 16:887-891.

53. Tarry CT, Chiles C, Cole TJ. A COPD patient with an air-fluid level. Journal of Respiratory Diseases 1996; 17:243-249.

54. Cox JE, Choplin RH, Chiles C. Chemical-shift MR of exogenous lipoid pneumonia. J Comput Assist Tomogr 1996; 20:465-467.

55. Ferretti G, Chiles C. An abnormal chest film in a patient with bronchitis. Journal of Respiratory Diseases, 1996; 17:1033-1036.

56. Ely EW, Johnson MM, Chiles C, Rushing JT, Bowton DL, Freimanis RI, Choplin RH, Haponik EF. Chest x-ray changes in airspace disease are associated with parameters of mechanical ventilation in ICU patients. Am J Respir Crit Care Med 1996; 154:1543-1550.

57. Creasy JD, Chiles C, Routh WD, Dyer RB. Overview of traumatic injury of the thoracic aorta. RadioGraphics 1997; 17:27-45.

58. Ferretti GR, Chiles C, Cox JE, Choplin RH, Coulomb M. Localized benign fibrous tumors of the pleura: MR appearance. J Comput Assist Tomogr 1997; 21:115-120.

59. Aquino SL, Chiles C, Oaks T. Displaced extrapleural fat as revealed by CT scanning: evidence of extrapleural hematoma. AJR Am J Roentgenol 1997; 169:687-689.

60. Cox JE, Chiles C, Aquino SL, Savage P, Oaks T. Pulmonary artery sarcomas: a review of clinical and radiologic features. J Comput Assist Tomogr 1997; 21:750-755.

61. Chen MYM, Chiles C, Choplin RH, Aquino SL. Bronchogenic carcinoma: a survey of CT protocols for staging disease. Acad Radiol 1997; 4:687-692.

62. Chen MYM, Chiles C, Loggie BW, Choplin RH, Perini MA, Fleming RA. Thoracic complications in patients undergoing intraperitoneal heated chemotherapy with mitomycin following cytoreductive surgery. J Surg Oncol 1997; 66:19-23.

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BIBLIOGRAPHY (continued):
Journal Articles (continued:

63. Ferretti GR, Chiles C, Woodruff RD, Choplin RH. Epithelioid hemangioendothelioma of the superior vena cava: computed tomography demonstration and review of the literature. J Thorac Imaging 1998; 13:45-48.

64. Thomason JWW, Ely EW, Chiles C, Ferretti G, Freimanis RI, Haponik EF. Appraising pulmonary edema using supine chest roentgenograms in ventilated patients. Am J Respir Crit Care Med 1998; 157:1600-1605.

65. Aquino SL, Chiles C, Halford P. Distinction of consolidative bronchioloalveolar carcinoma from pneumonia: do CT criteria work? AJR Am J Roentgenol 1998; 171:359-363.

66. Aquino SL, Dunagan DP, Chiles C, Haponik EF. Herpes simplex virus 1 pneumonia: patterns on CT scans and conventional chest radiographs. J Comput Assist Tomogr 1998; 22:795-800.

67. Chiles C, Davis KW, Williams DW III. Navigating the thoracic inlet. RadioGraphics 1999; (in press)

Abstracts:

1. Chiles C, Ravin CE. Radiographic recognition of pneumothorax in the intensive care unit. Crit Care Med 1986; 14:677-680; Respiratory Diseases Digest 1987; 4:5-6.

2. Tarry CT, Chiles C, Cole TJ. Fluid accumulation within a preexisting bulla. Radiology 1993; 189(P):433.

3. Chiles C, Bampton AH, Blinder RA. MR imaging of the thorax: selection of imaging parameters. Radiology 1993; 189(P):431.

4. Chen MY, Chiles C, Choplin RH. A survey of CT protocols for staging bronchogenic carcinoma. AJR Am J Roentgenol 1995; 164(3 Suppl):27-28.

5. Johnson MM, Ely EW, Chiles CC (sic), Rushing DL, Bowton DL Freimanis RI, Choplin RH, Haponik EF. Detection of hyperinflation (H) on portable chest x-rays (CXRs). Am J Respir Crit Care Med 1995; 151:A327.

6. Ely EW, Johnson MM, Chiles CC (sic), Bowton DL, Rushing JR, Freimanis RI, Choplin RH, Haponik EF. Objective chest x-ray (CXR) measurements correlate with mechanical ventilator parameters in ICU patients. Am J Respir Crit Care Med 1995; 151:A334.

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BIBLIOGRAPHY (continued):
Abstracts (continued):

7. Thomason JWW, Ely EW, Chiles C, Ferretti G, Freimanis R, Haponik EF. Radiologic evaluation of pulmonary edema in mechanically ventilated ICU patients using supine portable chest x-rays. Am J Respir Crit Care Med 1996; 153:A194.

8. Aquino SL, Chiles C, Chen MYM, Kuo W. Pleural and extrapleural disease in patients with lymphoma: findings on CT scans. AJR Am J Roentgenol 1998; 170(Suppl):17-18.

9. Aquino SL, Dunnagan D, Chiles C, Haponik E. Herpes simplex 1 pneumonia: patterns on CT scans and conventional chest radiographs. AJR Am J Roentgenol 1998; 170(Suppl):62.

10. Gilbert S, Chiles C, Aquino SL. The extrapleural space. Radiology 1998; 209(P):554.

11. Chiles C, Woodard PK, Gutierrez FR, Link KM. Metastatic involvement of the heart and pericardium. Radiology 1998; 209(P):554.

Scientific Exhibits:

1. Chiles C, MacGregor JH, Silverman PM. CT appearance of the chest wall following treatment of breast cancer. Exhibited at the American Roentgen Ray Society 87th Annual Meeting. Miami Beach, Florida, April 1987.

2. Chiles C, Newman GE. The bronchial circulation in sheep following multiple pulmonary emboli. Exhibited at the Association of University Radiologists meeting. New Orleans, Louisiana, April 1988.

3. Sherrier RH, Chiles C, Newman GE. Vascular casts of the bronchial circulation. Exhibited at the Association of University Radiologists meeting. New Orleans, Louisiana, April 1988.

4. Bergin C, Coblentz C, Roggli V, Chiles C, Ravin CE. The secondary lobule: diseases affecting lymphatic channels. Exhibited at the American Roentgen Ray Society 88th Annual Meeting, San Francisco, California, May 1988, and at the 74th Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1988. (Certificate of Merit, RSNA, November 1988.)

5. Chiles C, Blinder RA, Bampton AEH. Surface coil MR imaging of the chest wall in patients with peripheral bronchogenic carcinoma. Exhibited at the 78th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 1992. Abstract: Radiology 1992; 185(P):355.

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6. Tarry CT, Chiles C, Cole TJ. Fluid accumulation within a preexisting bulla. Exhibited at the 79th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 1993. Abstract: Radiology 1993; 189(P):433.

7. Chiles C, Bampton AH, Blinder RA. MR imaging of the thorax: selection of imaging parameters. Exhibited at the 79th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 1993. Abstract: Radiology 1993; 189(P):431.

8. Johnson MM, Ely EW, Chiles C, Bowton DL, Rushing DL, Freimanis RI, Choplin RH, Haponik EF. Detection of hyperinflation (H) on portable chest x-rays (CXRs). Exhibited at the American Thoracic Society meeting. Seattle, Washington, May 21-24, 1995. Abstract: Am J Respir Crit Care Med 1995; 151:A327.

9. Ely EW, Johnson MM, Chiles C, Bowton DL, Rushing JR, Freimanis RI, Choplin RH, Haponik EF. Objective chest x-ray (CXR) measurements correlate with mechanical ventilator parameters in ICU patients. Exhibited at the American Thoracic Society meeting. Seattle, Washington, May 21-24, 1995. Abstract: Am J Respir Crit Care Med 1995; 151:A334.

10. Chen MY, Chiles C, Choplin RH. Survey of CT protocols for staging of bronchogenic carcinoma. Exhibited at the Annual Meeting of the American Roentgen Ray Society 95th Annual Meeting, Washington, DC, May 1, 1995, and at the 81st Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago, Illinois, November 1995. Abstract: Am J Roentgenol 1995; 164:(3Suppl):27-28, and Radiology 1995; 197(P):528.

11. Creasy JD, Chiles C, Routh WD, Dyer RB. Traumatic thoracic aortic injury: pictorial review. Exhibited at the 81st Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 1995. Abstract: Radiology 1995; 197(P):528.

12. Ely EW, Johnson MM, Chiles C, Rushing JT, Bowton DL, Freimanis RI, Choplin RH, Haponik EF. An objective protocol in ventilated patients shortens weaning time. Exhibited at the American Thoracic Society International Conference. New Orleans, Louisiana, May 11-15, 1996.

13. Davis KW, Chiles C, Williams DW III. Navigating the thoracic inlet. Exhibited at the 83rd Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 30 - December 5, 1997. (Magna Cum Laude Award) Abstract: Radiology 1997; 205(P):681.

14. Gilbert S, Chiles C, Aquino SL. The extrapleural space. Exhibited at the 84th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 29-December 4, 1998. Abstract: Radiology 1998; 209(P):554.

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15. Chiles C, Woodard PK, Gutierrez FR, Link KM. Metastatic involvement of the heart and pericardium. Exhibited at the 84th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 29-December 4, 1998. Abstract: Radiology 1998; 209(P):554.

Miscellaneous:

1. Loehr SP, Aquino S, Hagenstad C, Chiles C. CT appearance of talc pleurodesis: comparison with metastases. San Juan, Puerto Rico. Syllabus, Thoracic Imaging 1998:268.

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Wake Forest University School of Medicine
Caroline Chiles, M.D.
Teaching Portfolio

RECURRENT TEACHING RESPONSIBILITIES (INTRAMURAL)

A. Medical Students

Lectures:

1. Unit VI Radiology, 4th-year medical students — 1994-
Eighteen 1-hour lectures per year
Bowman Gray School of Medicine

2. Unit V Radiology, 3rd-year medical students — 1994-1996
One-hour lectures 9 times per year
Bowman Gray School of Medicine

3. Units III-IV Radiology, 2nd-year medical students — 1996-
One-hour lectures plus two hours with small groups, once per year
Bowman Gray School of Medicine

4. Units I-II Radiologic Anatomy, 1st-year medical students — 1996-
One-hour lectures plus two hours with small groups, once per year
Bowman Gray School of Medicine

Small Group:
See #3 and #4 above

Evaluator:
None

Course/Clerkship Director:

Course Director:
Unit VI Radiology Elective for 4th-year medical students — 1996-
Bowman Gray School of Medicine

Other:

Coordinator: Radiology Instruction for Physician's Assistant Students — 1986-1990
Duke University Medical Center

Coordinator: Radiology Rotation for Family Medicine Residents — 1988-1990
Duke University Medical Center

Coordinator: Wilhelm Roentgen Society (a radiology interest group) — 1996-
Bowman Gray School of Medicine students

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RECURRENT TEACHING RESPONSIBILITIES (INTRAMURAL) (continued)
A. Medical Students (continued):

Sponsor: NIH Medical Student Research 6/97-8/97
Training Program Summer Research Project
Kuo WT: Evaluation of Contrast CT of Lymphoma of the Pleura
Bowman Gray School of Medicine

B. Graduate Education

Lectures:

Radiology Residents and Thoracic Imaging Fellows 1994 -
One-hour per month - 7:30 a.m. formal lectures
One-hour per month - 12:30 p.m. case conferences
Bowman Gray School of Medicine

Small Group:

Daily teaching: one-on-one basis at alternator, teaching interpretation of CXR, chest CT, chest MR; instruction in performing lung biopsies and pleural drainages 1994 -

Program director:
None

Thesis and examination committees:
None

Other:
None

C. Other Health Professional Students:

Lectures:
None

Small Group:
None

Other:
None

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D. Continuing Medical Education:

Internal - WFUBMC/WFUSM programs;

I participate annually in either winter or summer CME programs given by the Department of Radiology.
Two lectures per meeting.

E. Committees and Administration related to Medical Education:

Unit V/VI committee for medical student curriculum 1996-1997
Curriculum 2002 Committee

F. Mentoring/Advising:

None

RECURRENT TEACHING RESPONSIBILITIES (EXTRAMURAL)

None

AWARDS FOR TEACHING AND MEDICAL EDUCATION:

Certificate of Merit 1988
The secondary lobule: diseases affecting lymphatic channels [Scientific Exhibit]
74th Scientific Assembly and Annual Meeting of the Radiological Society of North America

Radiology Resident Teaching Award 1990
Duke University Medical Center
Durham, North Carolina

Magna Cum Laude Award 1997
Navigating the thoracic inlet [Scientific Exhibit]
83rd Scientific Assembly and Annual Meeting of the Radiological Society of North America

LECTURES AND ORAL PRESENTATIONS:

1. Chiles C, Ravin CE. Physical properties governing the interrelationship of pressure, flow and volume in collapsible tubes. Presented at the Association of University Radiologists meetin. New Orleans, Louisiana, April 1981.

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LECTURES AND ORAL PRESENTATIONS (continued):

2. Chiles C, Guthaner D, Djang WT. Detection of pulmonary emboli in dogs using digital subtraction angiography. Presented at the Association of University Radiologists meeting. Mobile, Alabama, April 1983.

3. Chiles C, Guthaner DF, Jamieson SW, Stinson EB, Oyer PE, Silverman FJ. Heart-lung transplantation: the postoperative chest radiograph. Presented at the Association of University Radiologists meeting. Newport Beach, California, May 1984.

4. Chiles C, Blank N. Pneumocystis carinii pneumonia: the spectrum of clinical and radiographic presentation. Presented at the Association of University Radiologists meeting. Newport Beach, California, May 1984.

5. Chiles C, Hedlund LW, Kubek JR, Harris CC, Sullivan DC, Tsai JC, Putman CE. Peripheral distribution of large diameter microspheres in the dog lung in the axial plane. Presented at the Association of University Radiologists meeting. Nashville, Tennessee, May 1985.

6. Chiles C. Intrathoracic metastasis from an extrathoracic malignancy: a radiographic approach to patient evaluation. Presented at the Eighth Annual Duke Radiology Postgraduate Course. Pine Knoll Shores, North Carolina, August 2, 1985.

7. Chiles C. New imaging modalities. Presented at the Third Annual Winter Symposium: Selected Topics in Internal Medicine. Snowshoe, West Virginia, February 3-5, 1986.

8. Chiles C. Pulmonary masses. Presented at the First Annual Duke Radiology Review Course. Durham, North Carolina, April 28, 1986.

9. Chiles C. Introduction to cardiac radiology. Presented at the First Annual Duke Radiology Review Course. Durham, North Carolina, April 28, 1986.

10. Chiles C. Acquired heart disease. Presented at the First Annual Duke Radiology Review Course. Durham, North Carolina, April 28, 1986.

11. Chiles C. CT of the mediastinum in patients with lung cancer. Presented at the Ninth Annual Duke Radiology Postgraduate Course. Pine Knoll Shores, North Carolina, July 31, 1986.

12. Chiles C, Utz JA, Godwin JD, Herfkens RJ, Sabiston DC Jr. Imaging of congenital absence or stenosis of a pulmonary artery-new techniques. Presented at the 72nd Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, December 1986.

13. Chiles C, Newman GE, Blinder RA. SPECT imaging of the bronchial circulation in sheep. Presented at the Association of University Radiologists meeting. Charleston, South Carolina, March 1987.

14. Chiles C. Pulmonary masses. Presented at the Second Annual Duke Radiology Review Course. Durham, North Carolina, April 20, 1987.

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LECTURES AND ORAL PRESENTATIONS (continued):

15. Chiles C. Introduction to cardiac radiology. Presented at the Second Annual Duke Radiology Review Course.

16. Chiles C. Acquired heart disease. Presented at the Second Annual Duke Radiology Review Course. Durham, North Carolina, April 20, 1987.

17. Chiles C. Radiographic manifestations of rupture of the thoracic aorta. Presented at the Tenth Annual Duke Radiology Postgraduate Course. Pine Knoll Shores, North Carolina, July 27, 1987.

18. Chiles C. The thoracic aorta. Presented at the Duke University Medical Center, Department of Radiology, Fourteenth Annual Symposium of Diagnostic Imaging. Bermuda, October 12, 1987.

19. Chiles C. The chest wall - plain film and CT observations. Presented at the Duke University Medical Center, Department of Radiology, Fourteenth Annual Symposium of Diagnostic Imaging. Bermuda, October 14, 1987.

20. Chiles C. Intrathoracic metastasis from an extrathoracic primary. Presented at the Duke University Medical Center, Department of Radiology, Fourteenth Annual Symposium of Diagnostic Imaging. Bermuda, October 16, 1987.

21. Chiles C. The thoracic aorta; the chest wall-plain film and CT observations; and intrathoracic metastasis from an extrathoracic primary. Presented at the Department of Radiology, Wilford Hall Air Force Base, San Antonio, Texas, November 20, 1987.

22. Chiles C. Chest CT-when is it useful? Presented at the Selected Topics Symposium. Durham, North Carolina, February 15, 1988.

23. Chiles C. A review of chest radiology-pattern recognition. Presented at the First Annual Physician's Assistant Certification Review Course. Durham, North Carolina, March 4, 1988.

24. Chiles C. Pulmonary masses. Presented at the Third Annual Duke Radiology Review Course. Durham, North Carolina, April 25, 1988.

25. Chiles C. Introduction to cardiac radiology. Presented at the Third Annual Duke Radiology Review Course. Durham, North Carolina, April 25, 1988.

26. Chiles C. Acquired heart disease. Presented at the Third Annual Duke Radiology Review Course. Durham, North Carolina, April 25, 1988.

27. Chiles C. Lesions of the chest wall. Presented at the Eleventh Annual Duke Radiology Postgraduate Course. Pine Knoll Shores, North Carolina, July 28, 1988.

28. Chiles C. Aortic rupture. Presented at the Refresher Course, North Carolina Chapter of the American College of Radiology. Greensboro, North Carolina, November 5, 1988.

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LECTURES AND ORAL PRESENTATIONS (continued):

29. Vail CM, Chiles C, Coblentz CL, Carroll BA. Radiographic evaluation of intraaortic balloon pumps. Presented by Dr. Vail at the 74th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 1988.

30. Bergin CJ, Bell DY, Coblentz CL, Chiles C, Putman CE, MacIntyre N, Coleman E, Wilkinson WE. CT of sarcoidosis: variation and significance of parenchymal disease. Presented by Dr. Bergin at the 74th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Chicago, Illinois, November 1988.

31. Chiles C. A review of chest radiology-pattern recognition. Presented at the Second Annual Physician's Assistant Certification Review Course. Durham, North Carolina, March 3, 1989.

32. Chiles C. Pulmonary masses. Presented at the Fourth Annual Duke Radiology Review Course. Durham, North Carolina, April 1989.

33. Chiles C. Introduction to cardiac radiology. Presented at the Fourth Annual Duke Radiology Review Course. Durham, North Carolina, April 1989.

34. Chiles C. Acquired heart disease. Presented at the Fourth Annual Duke Radiology Review Course. Durham, North Carolina, April 1989.

35. Bergin CJ, Coblentz CL, Chiles C, Bell DY, Castellino RA. CT identification of chronic lung diseases. Presented by Dr. Bergin at the American Roentgen Ray Society 89th Annual Meeting. New Orleans, Louisiana, May 1989.

36. Bass J, Chiles C. Analysis of correlation between skills in visual perception and radiologic diagnostic performance. Presented by Dr. Bass at the Association of University Radiologists meeting. Seattle, Washington, May 1989.

37. Chiles C. High resolution CT in the diagnosis of pulmonary disease. Presented at the Ninth Annual Duke Radiology Postgraduate Course. Pine Knoll Shores, North Carolina, July 27, 1989.

38. Chiles C, Muller NL, Kullnig P. Pulmonary lymphangioleiomyomatosis: CT appearance and correlation with pulmonary function. Presented at the Society of Thoracic Radiology meeting. Naples, Florida, January 1990.

39. Chiles C. A review of chest radiology-pattern recognition. Presented at the Third Annual Physician's Assistant Certification Review Course. Durham, North Carolina, March 1990.

40. Department of Radiology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, March 23, 1990.

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LECTURES AND ORAL PRESENTATIONS (continued):

41. Chiles C. Pulmonary masses. Presented at the Fifth Annual Duke Radiology Review Course. Durham, North Carolina, April 1990.

42. Chiles C. Introduction to cardiac radiology. Presented at the Fifth Annual Duke Radiology Review Course. Durham, North Carolina, April 1990.

43. Chiles C. Acquired heart disease. Presented at the Fifth Annual Duke Radiology Review Course. Durham, North Carolina, April 1990.

44. Chiles C. CT of the chest. Presented at the Refresher Course, North Carolina Chapter of the American College of Radiology. Durham, North Carolina, May 18, 1990.

45. Department of Radiology, Vanderbilt University, Nashville, Tennessee, May 21-22, 1990.

46. Chiles C. Interstitial lung disease diagnosis with high-resolution CT. Presented at the Eastern Virginia Radiological Society meeting. Norfolk, Virginia, March 6, 1991.

47. Chiles C. The thoracic aorta-transection and dissection. Presented at the Department of Radiology, Eastern Virginia Medical School. Norfolk, Virginia, March 7, 1991.

48. Chiles C. CT of the pulmonary hilum. Presented at the Department of Radiology, Eastern Virginia Medical School. Norfolk, Virginia, March 7, 1991.

49. Chiles C. New film-screen combinations for chest radiology. Presented at the University of California at Los Angeles, Department of Radiology. Los Angeles, California, November 12, 1992.

50. Chiles C, Blinder RA, Bampton AEH. Chest wall invasion by bronchogenic carcinoma-spectral fat-suppressed gadolinium-enhanced MR imaging. Presented at the Society of Thoracic Radiology meeting. Hilton Head, South Carolina, March 1993.

51. Department of Radiology, Louisiana State University Medical Center. New Orleans, Louisiana, April 5-8, 1993.

52. Chiles C, Blinder RA, Bampton AEH. Chest wall invasion by bronchogenic carcinoma-assessment with MR imaging. Presented at the Virginia Chapter of the American College of Radiology meeting. Williamsburg, Virginia, May 1993.

53. Chiles C. Aortic trauma. Presented at the Winter Radiology Continuing Education Program. sponsored by the Bowman Gray School of Medicine. Curaçao, Netherlands Antilles, January 21-28, 1995.

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LECTURES AND ORAL PRESENTATIONS (continued):

54. Chiles C. Staging of lung cancer. Presented at the Winter Radiology Continuing Education Program, sponsored by the Bowman Gray School of Medicine, Curaçao. Netherlands Antilles, January 21-28, 1995.

55. Chiles C. Chest MR - selection of scan parameters. Presented at the Winter Radiology Continuing Education Program, sponsored by the Bowman Gray School of Medicine. Curaçao, Netherlands Antilles, January 21-28, 1995.

56. Chiles C. High resolution CT of pulmonary parenchymal disease. Presented at the North Carolina Thoracic Society meeting. New Bern, North Carolina, April 8, 1995.

57. Chiles C. Aortic trauma. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine. Aruba, January 22-26, 1996.

58. Chiles C. High resolution CT of pulmonary parenchymal disease. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine, Aruba. January 22-26, 1996.

59. Chiles C. Extrathoracic staging of lung cancer. Presented at the Society of Thoracic Radiology meeting. Mauna Lani, Hawaii, February 18, 1996.

60. Chiles C. When to order a CXR, and how to understand the report. Presented at Common Clinical and Practice Skills Symposium, Southern Medical Association. Atlanta, Georgia, April 26, 1996.

61. Thomason JWW, Ely EW, Chiles C, Ferretti G, Haponik EF. Radiologic evaluation of pulmonary edema in mechanically ventilated ICU patients using supine portable chest x-rays (CXR). Presented by Mr. Thomason (MS) at the American Thoracic Society International Conference. New Orleans, Louisiana, May 11-15, 1996.

62. Chiles C. Pleural drainage catheter placement. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine. Aruba, January 19-25, 1997.

63. Chiles C. Extrathoracic staging of lung cancer. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine. Aruba, January 19-25, 1997.

64. Chiles C. High-resolution CT of pulmonary parenchymal disease. Presented at the Winter Radiology Continuing Education Program, sponsored by Bowman Gray School of Medicine. Aruba, January 19-25, 1997.

65. Ferretti G, Lörcher U, Chiles C, Thony F, Coulomb M. Chest imaging in HIV-positive patients (Part I). Presented by Dr. Ferretti at the AIDS European Congress of Radiology, Vienna, Austria. March 2-7, 1997.

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LECTURES AND ORAL PRESENTATIONS (continued):

66. Chiles C. High-resolution CT of pulmonary parenchymal disease. Presented at the Low Country Radiology Society. Charleston, South Carolina, April 21, 1997.

67. Chiles C. A radiographic approach to diffuse lung disease. Presented at the Department of Radiology, Medical University of South Carolina. Charleston, South Carolina, April 21, 1997.

68. Chiles C. Staging lung cancer. Presented at the Foothills Hospital, Department of Radiology, University of Calgary. Calgary, Alberta, Canada, February 19-20, 1998.

69. Chiles C. High resolution CT of lung disease. Presented at the Foothills Hospital, Department of Radiology, University of Calgary. Calgary, Alberta, Canada, February 19-20, 1998.

70. Chiles C. Extrathoracic staging of lung cancer. Presented at the Society of Thoracic Radiology annual meeting. San Juan, Puerto Rico, March 9, 1998.

71. Chiles C. Blunt trauma of the great vessels in an era of multi-modalities. Presented at the 9th Annual Meeting of the American Society of Emergency Radiology. St. Petersburg, Florida, April 8, 1998.

72. Chiles C. Staging lung cancer. Presented at the Annual Meeting of the North Carolina Thoracic Society. Chapel Hill, North Carolina, April 8, 1998.

71. Ely EW, Smith AC, Chiles C, Aquino SL, Evans GW, Haponik EF. Portable digital chest radiography (DCR): Appraising its clinical utility in distinguishing pulmonary edema. Presented by Dr. Ely at the American Lung Association/American Thoracic Society International Conference. Chicago, Illinois, April 24-29, 1998.

72. Aquino SL, Chiles C, Chen MYM, Kuo W. Pleural and extrapleural disease in patients with lymphoma: findings on CT scans. Presented by Dr. Aquino at the American Roentgen Ray Society 98th Annual Meeting. San Francisco, California, April 26-May 1, 1998.

73. Aquino SL, Dunagan D, Chiles C, Haponik E. Herpes simplex 1 pneumonia: patterns on CT scans and conventional chest radiographs. Presented by Dr. Aquino at the American Roentgen Ray Society 98th Annual Meeting. San Francisco, California, April 26-May 1, 1998.

74. Chiles C. Imaging the thorax: CXR and CT. Presented at the Wake Forest University School of Medicine Internal Medicine Boards Review Course, Winston, Salem, North Caroline, June 4, 1998.

75. Chiles C. High resolution CT of the lungs. Presented at the Wake Forest University School of Medicine Summer Radiology Continuing Education Program, Hilton Head, South Carolina, June 26, 1998.

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LECTURES AND ORAL PRESENTATIONS (continued):

76. Chiles C. The new staging system for lung cancer. Presented at the Wake Forest University School of Medicine Summer Radiology Continuing Education Program, Hilton Head, South Carolina, June 26, 1998.

77. Chiles C. Radiographic distinction of cardiogenic and noncardiogenic edema. Presented at the American Thoracic Society, Workshop on Radiographic Definitions of Lung Injury. Seattle, Washington, August 29, 1998.

78. Chiles C. Community acquired pneumonia. Presented at Massachusetts General Hospital, Department of Radiology. Boston, Massachusetts, September 30, 1998.

79. Chiles C. Staging of bronchogenic carcinoma. Presented at the Department of Radiology, Brooke Army Medical Center. Fort Sam Houston, San Antonio, Texas, November 2, 1998.

80. Chiles C. Staging of bronchogenic carcinoma. Presented at the Department of Radiology, Wilford Hall Medical Center, Lackland AFB. San Antonio, Texas, November 2, 1998.

81. Chiles C. Staging of bronchogenic carcinoma. Presented at the Department of Radiology, University of Texas. San Antonio, Texas, November 2, 1998.

82. Chiles C. Thoracic aortic trauma. Presented at the Department of Radiology, Brooke Army Medical Center. Fort Sam Houston, San Antonio, Texas, November 3, 1998.

83. Chiles C. Thoracic aortic trauma. Presented at the Department of Radiology, Wilford Hall Medical Center, Lackland AFB. San Antonio, Texas, November 3, 1998.

84. Chiles C. Recognition of lymph nodes on CXR and CT's. Presented at the Winter Radiology Continuing Education Program. St. Thomas, Virgin Islands, February 13-19, 1999.

85. Chiles C. High resolution CT of lung disease. Presented at the Winter Radiology Continuing Education Program. St. Thomas, Virgin Islands, February 13-19, 1999.

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